



# Medicaid Autism Spectrum Disorder Screening, Evaluation and Treatment Recommendation Best Practice Guidelines

## Acknowledgements

*The Michigan Medicaid Autism Spectrum Disorder Screening, Evaluation and Treatment Recommendation Guidelines* is the result of a dedicated Workgroup of professionals who work daily with children with Autism Spectrum Disorder and their families and Michigan Department of Health and Human Services staff who strive daily to ensure quality and integrity of Medicaid services.

The quality of the Guidelines reflects the expertise and dedication from the Leadership and Workgroup Members, and Michigan families are grateful for this high level of commitment from professionals. Thank you to the Workgroup Leadership Team and Workgroup Members for your active, effective and collaborative process on the Guidelines.

### Workgroup Leadership Team:

- Kara Brooklier, PhD, LP
- Lisa Grost, MHSA
- Mary Luchies, PhD, LP, BCBA
- George Mellos, MD
- Sarah Witherell, PhD, LP
- Crystal Young, PhD, LP

### Workgroup Members:

- Ruth Anan, PhD, LP, BCBA-D
- Louis Bersine, LLP, BCBA
- T'Shara Cannon, LPC
- Barb Groom, LLP
- Matthew Hambleton
- Ramzi Hasson, PhD
- Stefani Hines, MD
- Dana Lasenby, LLP
- Mira Krishnan, PhD, LP
- Jenny Radesky, MD
- Thomas Renwick, JD
- Shana Rush, PhD, LP, CCC-SLP
- Neelkamal Soares, MD

## **Introduction**

The Michigan Department of Health and Human Services includes the Michigan Medicaid Autism Services for children under the Medicaid Services Administration and Behavioral Health and Developmental Disabilities Administration. The Michigan Medicaid System is comprised of Medicaid Health Plans (MHP), Prepaid Inpatient Health Plans (PIHP) and Community Mental Health Service Programs (CMHP) to provide the Medicaid Autism Services.

The Medical Services Administration manages the Michigan Medicaid Health Plans which provide the medical and physical evaluations, screenings as well as medically necessary speech and language, occupational and physical therapies.

The Behavioral Health and Developmental Disabilities Administration contracts with PIHPs and CMHPs to provide the management and services of diagnostic evaluations, behavioral health treatment plans, Applied Behavior Analysis Services (ABA), family trainings as well as substance abuse prevention and treatment, mental health, and developmental disability services.

The Michigan Medicaid Autism Screening, Evaluation and Treatment Recommendation Guidelines were developed to improve the statewide standardization of Autism Services for children. These Guidelines were a recommendation from the Medicaid Autism Services – Workgroup Recommendations Report (FY2019 Appropriations Act – Public Act 207 of 2018) Section 959 published March 1, 2019.

These Guidelines align with the Michigan Medicaid Policy, Provider Manual and Codes and Michigan licensing requirements to provide in-depth guidance for health care providers, administrators, families and service agencies. MDHHS strives to provide equitable and quality health care services to all children and families.



## Table of Contents

### **Chapter 1: Understanding and Screening for Autism Spectrum Disorder ..... 1**

Autism Spectrum Disorder: An Overview.....	1
Diagnostic and Statistical Manual, Fifth Edition (DSM-5).....	1
Applied Behavior Analysis.....	3
Policy for Screening for ASD.....	4
Roles and Responsibilities for Medicaid Health Plans and Primary Care Providers .....	4
Considerations for Screening of ASD .....	5
ASD-Specific Measures.....	6
General Developmental Measures.....	6
Referral Process for ASD Evaluation .....	6

### **Chapter 2: Evaluator Credentials, Supervision, & Professional Development ..... 11**

Evaluator Credentials, Skill Set & Qualified Licensed Practitioner (QLP) Criteria .....	11
Referral Screening & Follow-Up Consultation Considerations .....	12
Evaluator Supervision Requirements .....	13
Evaluator Ongoing Training & Professional Development.....	14

### **Chapter 3: Comprehensive Diagnostic ASD Evaluations ..... 17**

Policy for Michigan Medicaid Autism Services Evaluations.....	17
Medical Necessity Criteria for ASD.....	17
Essential Components of a Comprehensive ASD Evaluation .....	18
The Clinical Interview & Caregiver Report of ASD Developmental	
Symptom History.....	22
Collateral Input & Record Review .....	24
Observational Assessment .....	24
Assessment of Developmental, Cognitive & Language Functioning.....	26
Adaptive Functioning .....	27
Medical Assessment & Referral .....	28
Assessment Considerations by Age & Development .....	29
Comorbid & Differential Diagnosis .....	30
Language Disorder .....	30
Developmental Delay .....	31
Intellectual Disability .....	31
Attention Deficit/Hyperactivity Disorder .....	32
Anxiety Disorders.....	32
Depressive Disorders.....	33
Trauma & Attachment Disorders.....	34
Psychotic Disorders .....	36
Visual & Auditory Sensory Impairments.....	36
Special Population Considerations .....	37
Evaluation of Very Young Children.....	37
First Time Evaluation of Teens and Adults.....	38
Cultural Issues in ASD Evaluation .....	38
Caregivers who have Limited Historical or Current Knowledge .....	40
Considerations when Individuals were Previously Diagnosed with ASD.....	41

<b>Chapter 4: Evaluation Results, Feedback, Recommendations for Management, &amp; Behavioral Health Service Eligibility.....</b>	<b>43</b>
Feedback on Comprehensive ASD Evaluations .....	43
Scheduling of the Feedback Session .....	43
Completing the Feedback Session.....	44
Sharing Diagnostic Information and Recommendations.....	45
Clinical Report.....	46
Report Components .....	47
Summary of Report Writing and Organization.....	49
Recommendations, Referrals, and Treatment Considerations.....	51
Applied Behavioral Analysis (ABA).....	52
Other Evidence-Based Therapy Services for ASD.....	53
Medical Services and Referrals .....	54
Ancillary Services and Supports.....	55
Educational Services.....	56
Parent/Family Support and Community Resources.....	56
Alternative Treatments .....	57
Recommendations and Treatment Considerations when a Child Does not Qualify for ASD Diagnosis.....	58
<b>Chapter 5: Michigan Autism Services Eligibility &amp; Management for Individuals Receiving ABA.....</b>	<b>59</b>
Determining Medical Necessity for Autism Services.....	59
Completion of the WSA Form.....	62
Annual Re-evaluations .....	64
Discharge Planning.....	67
Second Opinion Evaluations .....	67
Conducting Second Opinion Evaluations.....	68
<b>Chapter 6: Michigan Medicaid Autism Services Myths.....</b>	<b>71</b>
<b>References.....</b>	<b>75</b>
<b>Appendices.....</b>	<b>87</b>
Appendix A: Michigan Medicaid Autism Services Policy .....	87
Appendix B: QLP Capacity Form .....	97
Appendix C: Supervision Requirements by Licensure Type.....	99
Appendix D: Michigan Medicaid Autism Services Supervisor Attestation Form.....	101
Appendix E: Michigan Medicaid Autism Services CPT Codes .....	103
Appendix F: Michigan Medicaid Autism Services Supervision Method Form .....	107
Appendix G: ASD Developmental Symptom History Interview .....	109
Appendix H: CDC Vaccination Schedules 0 to 6 & 7 to 18.....	113
Appendix I: ASD Assessment by Age Best Practice .....	123
Appendix J: ASD Evaluation Quality Checklist.....	131
Appendix K: Sample Report Templates .....	133
Appendix L: MI ASD Council Handout for Providers (Referrals for Young Children with ASD).....	143
Appendix M: MI ASD Council Handout for Parents (After ASD Diagnosis) .....	147
Appendix N: WSA Form Standard Template .....	149
Appendix O: Michigan Medicaid Autism Services Glossary of Terms .....	153

# Chapter 1.

## Understanding and Screening for Autism Spectrum Disorder

### *Autism Spectrum Disorder: An Overview*

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder characterized by impairment in reciprocal social interaction skills and communication as well as the presence of restricted, repetitive, and/or stereotyped patterns of behavior, interests, and activities. These features result in marked impairment in social interaction, language used in social communication, and symbolic or imaginative play. Features of the disorder are present early in development. Sensorimotor differences are detectable as early as six months of age, particularly for those with severe ASD (Teitelbaum et al., 1998). Presentation of ASD symptoms changes over the course of development, and a person's development is affected by having ASD.

The term ASD refers to a broad range of conditions as the presentation of symptoms may vary from one person to the next with contribution of a combination of genetic and environmental factors. Etiology of ASD is not yet fully understood research suggests several genetic and environmental influences that increase risk that a child will develop ASD. Autism tends to run in families with several genes associated with increased risk for ASD (Bailey et al., 1995; Folstein & Rosen-Sheidley, 2001; Skuse, 2000). Additionally, certain environmental factors may further increase the risk for individuals who are genetically predisposed to ASD. Increased risk has been linked to advanced parental age, pregnancy and birth complications (including exposure to certain medications in-utero, extreme prematurity, multiple pregnancies), and male gender (Williams et al., 2001; Williams & Hersh, 1997; Moore et al., 2000; Rasalam et al., 2005; Mahoney et al., 2013; Lee et al., 2015; Durkin et al., 2008). While etiological factors are not yet fully understood, prevalence is increasing over time. Males are four times more likely to develop ASD. Additionally, ASD affects individuals of all racial, ethnic, and socioeconomic groups.

Research has demonstrated considerable impact on families for a person diagnosed with ASD, including higher rates of health concerns as well as financial strain (Bekhet et al., 2012; Saunders et al., 2015).

Intervention provided should incorporate the needs of the family as a whole with a partnership established between family members and service providers.

Individuals with ASD often require a multidisciplinary approach to intervention, as several conditions are commonly comorbid with an ASD diagnosis, including intellectual disability and language delays. When an ASD diagnosis is established, the clinician should specify with or without intellectual impairment as well as with or without language impairment.

For further information regarding commonly comorbid conditions, see the "Comorbid and Differential Diagnosis" section of Chapter 3.

### *Diagnostic and Statistical Manual, Fifth Edition (DSM-5)*

Diagnostic classification for ASD has changed with the most recent publication of the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) (APA, 2013). Establishment of an ASD diagnosis and use of the DSM-5 requires specialized training (for more detail, see Chapter 2 on evaluator credentials). The former version of the diagnostic manual (DSM-IV-TR) listed Autism under a category of Pervasive Developmental Disorders, along with other disorders including Asperger Syndrome and Pervasive Developmental Disorder,

Not Otherwise Specified (PDD NOS). In the current DSM-5, the disorders were merged into a single diagnosis, ASD, which reflects the range of symptom severity and presentation as a broad spectrum of neurodevelopmental disorders (see Figure 1.1).

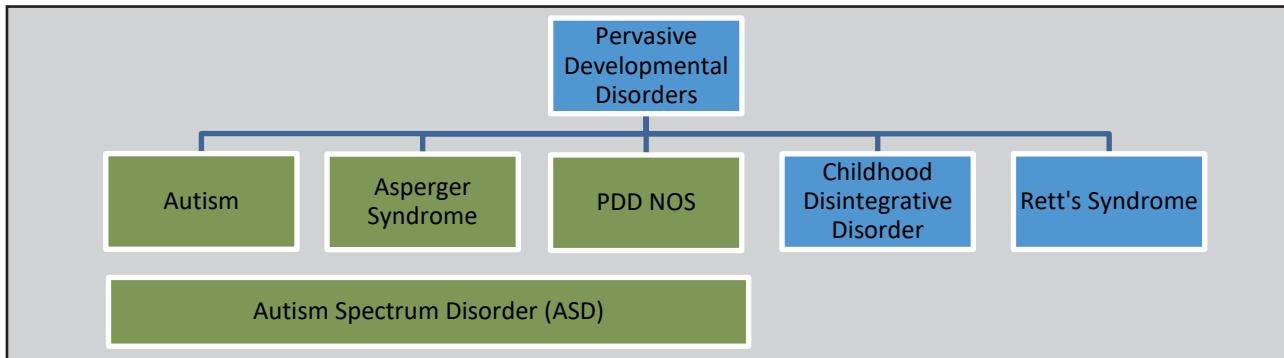


Figure1.1: Classification of Pervasive Developmental Disorders based on DSM-IV-TR Diagnostic Criteria

Diagnostic criteria for ASD, as listed in the DSM-5 is as follows:

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of the following, currently or by history (examples are illustrative, not exhaustive):
  1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.
  2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.
  3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.
- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least 2 of the following, currently or by history (examples are illustrative, not exhaustive):
  1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).
  2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).
  3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).
  4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).
- C. Symptoms must be present in the early developmental period (but may not fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).
- D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.



- E. These disturbances are not better explained by intellectual disability or global developmental delay. Intellectual disability and ASD frequently co-occur; to make comorbid diagnoses, social communication should be below that expected for general developmental level.

### ***Applied Behavior Analysis***

Applied Behavior Analysis (ABA) is the most evidence-based treatment for individuals with ASD (Cohen, Amerine-Dickens & Smith, 2006; Sallows & Graupner, 2005; Warren et al., 2011). ABA is a therapeutic approach based on principles of learning and behavior that involves identifying connections between an individual's behavior and antecedents and consequences of that behavior. This approach heavily utilizes positive reinforcement, which is the provision of something valued by an individual (a reward) immediately after the individual engages in a desired behavior. Behaviors that are consistently reinforced subsequently occur more often. Complex skills can be broken down into small steps and taught in a hierarchical fashion or gradually shaped by reinforcing successive approximations of the final behavioral goal. When treating problematic behavior, ABA focuses on understanding the function of the problem behavior when developing effective interventions. Although many of these principles of learning can be applied successfully outside of the context of ABA, this therapeutic approach must be practiced by professionals (in collaboration with family members) with appropriate clinical training.

ABA uses observation and measurement of behavior, including factors such as how often a particular behavior occurs, how long the behavior lasts, the antecedents that precede the behavior, and the consequences that follow the behavior. ABA services are provided by licensed board-certified behavior analysts (BCBAs), board-certified assistant behavior analysts (BCaBAs), qualified behavioral health professionals (QBHPs), and behavior technicians (BTs). BCaBAs, QBHPs, and BTs work under the supervision of the BCBA to implement the treatment plans written by the BCBA to meet established therapeutic goals. The ABA team collects data on behavior for the BCBA who modifies treatment plans, as needed. The BCBA also has weekly face to face time with the child being treated. Routine data collection and refinement of intervention plans based on the data are hallmarks of ABA.

Working with families, evaluators determine medical necessity for ABA and provide recommendations on high level treatment targets.

ABA services may be provided in-home or clinic-based with emphasis on practice and reinforcement of newly learned skills. The location of ABA services should be based on the best means for addressing the child's needs and family preference. ABA should be provided as much as possible, with the intensity (i.e., number of hours) to be determined by the treating ABA team. The amount of ABA a child receives should directly relate to the needs of the child and the skills and behaviors being targeted; this is evaluated in the behavioral assessment conducted by the BCBA in coordination with family need and input. All hours of ABA are intended to be goal-focused, and data is gathered to demonstrate if the intervention is resulting in progress toward the goal. Successful treatment typically includes modeling for parents and direct teaching provided for behavioral management and skill-building. Communication with other providers involved in treatment, including supports coordinators within the PIHP systems and school officials (when applicable and with consent provided by the parent/guardian) is also important.

ABA providers are tasked with the goal of improving socially significant behaviors, including communication, social skills, and adaptive living skills (e.g., independence with daily living skills, academic and work skills). There are many ways that ABA can be applied, including:

- Comprehensive Behavioral Intervention (an intensive behavioral intervention approach that emphasizes individual instruction for skill-building of communication, social interaction, and pre-academic skills).
- Focused skill-building (e.g., focusing on a specific goal such as toilet training, independence with self-care, use of community resources).
- Social skill building (in individual and group settings).
- Parent skills training (an evidence-based behavioral training approach that provides skill-building for management of child behavior).
- Problem behaviors (head banging & other self-injurious behaviors, physical aggression, elopement, difficulty following directions, destruction of property, inappropriate sexual behaviors, threatening others, sensory sensitivities, failure to remain seated, restrictive diets).

ABA can improve the quality of life for the individuals with ASD as well as their family.

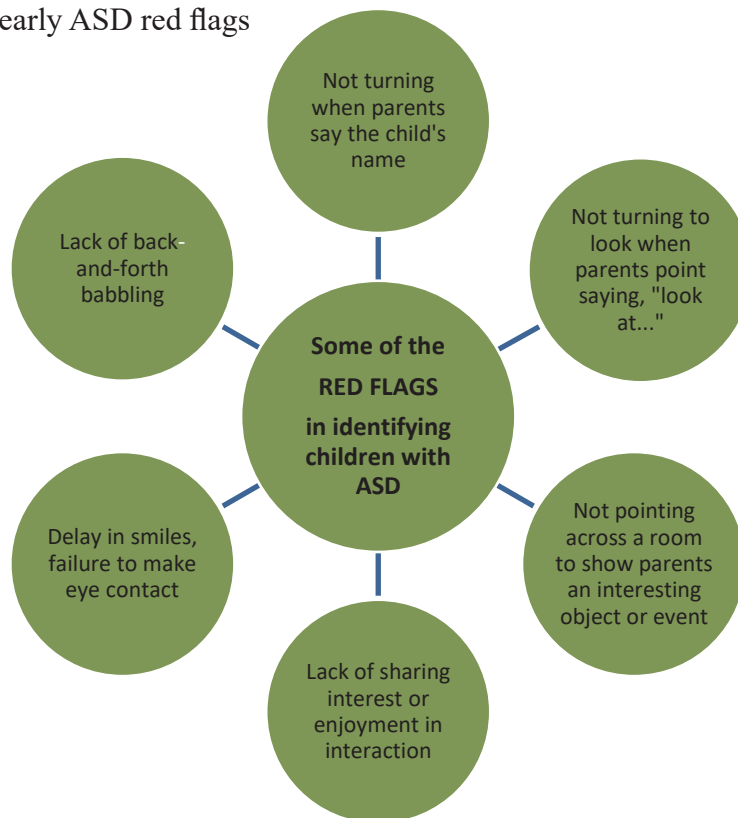
### ***Policy for Screening for ASD***

The Medicaid Provider Manual provided by Michigan Department of Health and Human Services (MDHHS) provides information regarding the policy for screening for ASD. The Centers for Disease Control and Prevention (CDC) shows approximately one in six children between the ages of 3 and 17 meet criteria for a developmental or behavioral disorder (CDC, 2019). The American Academy of Pediatrics (AAP) recommends that a standardized screening tool be used to assess general development at 9, 18, and 30 months of age (AAP, 2006). Additionally, AAP recommends all children receive developmental surveillance and screening for possible ASD at 18 and 24 months of age (Armstrong, 2008). Early entry into intervention is associated with improved treatment outcomes (Zwaigenbaum et al., 2015). The screening process is intended to identify children that show developmental concerns warranting an evaluation for possible ASD in order to link individuals with evidence-based treatment programs to promote optimal outcomes. Further information regarding policy language may be found in Appendix A.

### ***Roles and Responsibilities for Medicaid Health Plans and Primary Care Providers***

Screening for developmental disorders including ASD is typically completed during a well child visit with a child's primary care provider (PCP). Information gathered by PCPs should include birth history and developmental history, documentation of developmental milestones, and immunization history. Assessment of medical factors common in children with developmental delays (including seizures, hearing problems, sleep difficulties, diet, and self-injurious behaviors) as well as documentation of history of brain injury are also important. PCPs should also review educational history and previous intervention services provided as well as family history of ASD or other developmental concerns. If concerns about development are raised through developmental surveillance or information gathered, it is important that assessment be completed when concerns first became evident in a child's development. See Figure 1.2 for further information regarding some important clinical signs, or red flags, when conducting early childhood screening for ASD. More information on ASD red flags can be found at [www.nationalautismcenter.org/autism/early-signs/](http://www.nationalautismcenter.org/autism/early-signs/) and [www.firstsigns.org](http://www.firstsigns.org).

Figure 1.2. Some notable early ASD red flags



Although an ASD diagnosis is typically established in childhood, some individuals (particularly those with more mild symptoms) may not be identified or diagnosed until later in life when impairment becomes evident. ASD should be understood as a pervasive (lifelong) disability that influences one's development and may present differently or require specific intervention approaches over the person's lifespan. Assessment must be flexible and sensitive to developmental changes over time.

The Council on Children with Disabilities lists five components of developmental surveillance that are important for routine care (AAP, 2006):

1. Asking parents about their concerns.
2. Obtaining and documenting developmental history as well as tracking progress for age-based expectations.
3. Observing the child's development and using reliable standardized measures.
4. Identifying risk and protective factors.
5. Documenting and sharing an accurate record of the findings.

### ***Considerations for Screening of ASD***

Several validated and accessible measures exist for screening of ASD. Measures are easily administered, are completed by parents/guardians, and are not time-intensive. Some measures serve as a screening for general developmental progress, whereas other measures are ASD-specific. Clinicians should select a validated screening measure most appropriate for the child's age and clinical need. The following are

some recommended screening measures to consider; however, the list below is not intended to provide a comprehensive list of all available or recommended measures. For further information regarding available screening measures, please see [www.screeningtime.org](http://www.screeningtime.org), provided as a resource through the American Academy of Pediatrics for support with developmental screening.

### Some ASD-Specific Measures

- *Modified Checklist for Autism in Toddlers, Revised, with Follow-Up (M-CHAT-R/F) – ages 16 to 30 months (Robins et al., 2009)*  
The M-CHAT-R/F includes 20 items in yes/no format that screen for ASD symptoms. The measure is free to access, can be quickly and easily scored, and may be completed online or in paper/pencil format. Parents complete the questionnaire, and if a child screens positive based on parent responses, select follow-up interview items are administered. A flowsheet of interview items is available with pass/fail criteria established. A child is screened as positive on the interview if he or she fails any two items on the follow-up. If screened as positive, a child is considered at-risk for a developmental disorder and should be referred for evaluation as soon as possible. Of note, this measure is available for use in several languages. For a list of available translations please see the following website: <https://mchatscreen.com/mchat-rf/translations/>
- *Autism Screening Instrument for Educational Planning – Third Edition (ASIEP-3): Autism Behavior Checklist (ABC) – ages 2 years to 13 years, 11 months (Krug, Arick & Almond, 2008)*  
The ABC is a 47-item checklist of behaviors associated with ASD, as part of the ASIEP-3. The ASIEP-3 also includes measures of vocal behavior, spontaneous social interaction, functional educational skills, and learning rate.
- *Social Communication Questionnaire (SCQ) – ages 4+ (Rutter, Bailey & Lord, 2003)*  
The SCQ is a parent questionnaire with 40 items in yes/no format. The questionnaire is quick to complete and easily scored. Of note, the SCQ was designed for specificity, which creates weakness as a screening instrument. The SCQ is also available in Spanish.

### Some General Developmental Measures

- *Ages and Stages Questionnaires, Third Edition (ASQ-3) – ages 1 month to 5 ½ years (Squires et al., 2009)*  
The ASQ-3 may be distributed online or in paper format for parents to complete. The questionnaire is available in several languages. Parents answer questions related to general developmental progress by selecting “yes,” “sometimes,” or “not yet” to items. Of note, an Ages and Stages Questionnaires: Social-Emotional, Second Edition (ASQ: SE-2) is also available for use.
- *Child Development Inventory (CDI) – ages 15 months to 6 years (Ireton, 1992)*  
The CDI is completed by parents to assess development in eight areas of functioning: social, self-help, gross motor, fine motor, expressive language, language comprehension, letters, and numbers.

### Referral Process for ASD Evaluation

If concerns for possible ASD are present, PCPs should refer the child for further diagnostic evaluation. A positive screening should result in a referral for evaluation as soon as possible, given the importance of early intervention. The PCP should call the local Pre-paid Inpatient Health Plan (PIHP) in the geographic service area for Medicaid beneficiaries to make the referral directly. This may also include PCP staff assisting the family while in the office in contacting the PIHP directly to arrange for evaluation. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. PIHPs are then responsible for contacting, scheduling, and arranging the comprehensive diagnostic evaluation with the appropriate evaluator or evaluation team.

Individuals with ASD commonly present with one or more comorbid medical and/or psychiatric diagnoses (Matson & Nebel-Schwalm, 2007; Simonoff et al., 2008; Lugnegard et al., 2011). If the PCP determines child is also in need of consultation with other medical specialties or services, a referral should be made directly.

Common referrals to other providers are necessary for children with ASD or suspected developmental delay include but are not limited to:

- |                                       |                           |                                      |
|---------------------------------------|---------------------------|--------------------------------------|
| • Neurology                           | • Audiology               | • Occupational therapy               |
| • Genetics                            | • Vision screening        | • Gastroenterology                   |
| • Sleep specialist                    | • Psychiatry              | • Feeding program                    |
| • Developmental Behavioral Pediatrics | • Speech/Language therapy | • Physical Medicine & Rehabilitation |

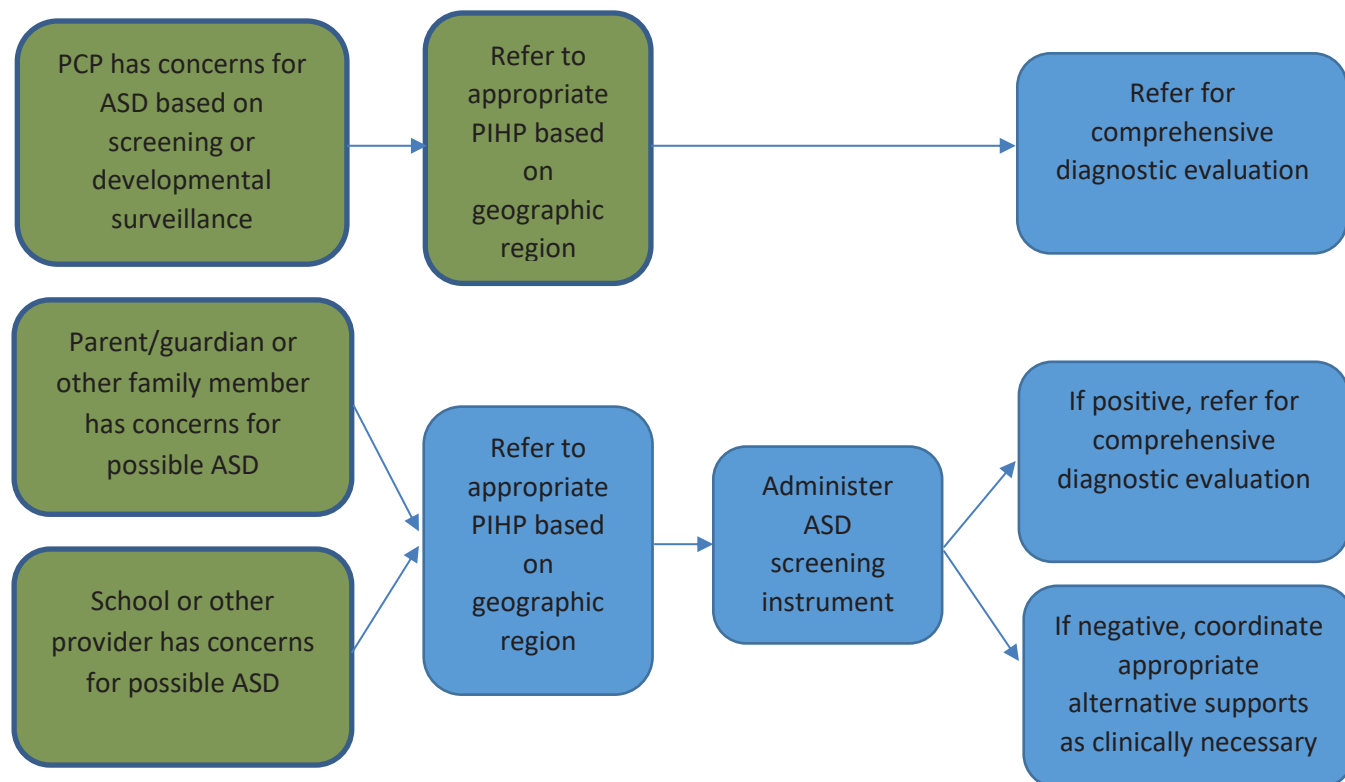
Referrals for evaluation of possible ASD may also come from other sources including schools, Early On, other involved clinicians, or from family members. Families referred to their local PIHP will undergo screening to determine if evaluation for ASD appears clinically useful. Clinicians conducting ASD screenings should utilize an appropriate screening measure to determine if a more comprehensive evaluation appears warranted. Clinicians should be welcoming and assist caregivers in describing their concerns for their child or loved one. The screening clinicians must be familiar enough with the clinical content of the screening questions to help the caregiver understand what is being asked by the items. The screening process is the first step in the family seeking help, and a supportive and welcoming attitude helps the family on the path to receiving the care needed. Clinicians should provide encouragement and emphasize the importance of early intervention for progress in services, given that early intensive behavioral intervention is associated with gains in developmental and cognitive skills (Eldevik, 2009; Howlin et al, 2009). If a screening is positive (suggesting concerns about possible ASD), the child will be referred to a local qualified licensed provider (QLP) for a comprehensive diagnostic evaluation. In cases that are deemed questionable or unclear (e.g., children presenting with borderline range symptoms but interference in home or school functioning, cases including trauma history or complicating factors, children whose clinical presentation does not appear to match parental responses on screening measures), PIHPs should error on the side of caution and refer those individuals for a more comprehensive evaluation. Families should have a *choice of evaluators* and be allowed to indicate preference for an evaluating agency or clinician, when available. Families who indicate preference for a particular agency or clinician should be permitted to make a selection that best fits the needs of their family, provided the referral falls within the scope of practice of the selected clinician or agency.

It is essential that clinicians support families throughout the screening process and remember some family members may have comprehension difficulties.

Of note, some parents may have difficulty completing screening measures accurately due to comprehension challenges, cognitive limitations, or learning difficulties. While screening measures are often a useful tool for identifying children who require more comprehensive assessment, caution should be exercised when parents show comprehension difficulties. In these cases, failure to complete a screening measure should not preclude a child’s access to an evaluation if the evaluation otherwise appears clinically warranted.

Importantly, referrals made by PCPs should be sent directly for comprehensive evaluation. Results of a screening measure should not rule out a referral or preclude a child’s access to an evaluation if that evaluation is clinically justified by the PCP. See Figure 1.3 for further guidance regarding appropriate steps when concern with possible ASD is raised.

Figure 1.3. Steps in the Referral and Screening Process for ASD Evaluations



Clinical directors within each PIHP serve the role of, organizing and directing referrals based on needs of the child to appropriate providers for evaluation. Each PIHP has a list of evaluators within the region and must be familiar with available agencies and evaluators, including skill set and experience. The evaluation process is independent from the treatment process; while evaluations can occur at possible receiving ABA treatment agencies, this should not be emphasized or mandated.

Complex or difficult evaluations should be directed to highly experienced, specialized evaluators competent in providing a full assessment of developmental/cognitive skills and differential diagnosis in the region to ensure an appropriate level of care. Quality of the evaluation is key.



Additionally, if a child is in foster care or has medical or psychiatric complexities that may impact the evaluation, the referral should be made to a highly experienced evaluator given the complexity of the case. It is not necessary that the child is referred to the same agency for both the initial evaluation and ABA, though that may occur.

The following should be considered complexities, and referral to a highly skilled evaluator who can conduct full psychological evaluation should be strongly considered whenever possible:

- Very young child (under age 3).
- Child in foster care or new caregiving situation.
- Experience of known trauma.
- Sensory impairment (hearing or vision).
- Mobility impairment (not yet walking, physical condition impacting ambulation).
- Medical conditions (e.g., extreme prematurity, seizure disorder, traumatic brain injury, known genetic condition, etc.).
- Psychiatric conditions known or highly suspected.
- Suspected intellectual disability.

It is especially important for cases with complexities that clinical directors within each PIHP refer families to well-trained, highly experienced evaluators for comprehensive assessment.





## Chapter 2.

### Evaluator Credentials, Supervision, & Professional Development

For full policy information, please reference the MDHHS Medicaid Provider Manual:  
<https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

#### *Evaluator credentials, skill set, & Qualified Licensed Practitioner (QLP) criteria*

Accurate and useful evaluation of ASD and associated conditions takes a combination of reliable and valid tool use, a review of robust history and presenting symptoms and needs, and clinician experience with the full range of ASD and associated conditions (Huerta & Lord, 2012). Minimally, clinicians completing evaluations for Michigan Medicaid Autism Services are required to meet Qualified Licensed Practitioner (QLP) evaluation criteria, as outlined in the policy (see Appendix A for autism services policy and Appendix B for QLP capacity form).

The diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. *A minimum of one year of experience in the assessment and diagnosis of ASD and related conditions is required to meet QLP criteria regardless of examiner licensing credential.*

A minimum of one year of experience in the assessment and diagnosis of ASD and related conditions is required to meet the QLP criteria regardless of examiner credential. Attendance at the ADOS-2 two-day training workshop is not sufficient for evaluators to be properly trained on the ADOS-2 or for ASD evaluation. Additional training and supervision are required.

A qualified licensed practitioner includes:

- Physicians
  - with a specialty in psychiatry or neurology;
  - with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics, or a related discipline;
  - with a specialty in pediatrics or other appropriate specialty with training, experience, or expertise in ASD and/or behavioral health;
- Psychologists (*licensed psychologists (LP), limited licensed psychologists (LLP), term limited licensed psychologists (TLLP) with required supervision*);
- Advanced practice registered nurses with training, experience, or expertise in ASD and/or behavioral health;
- Physician assistants with training, experience, or expertise in ASD and/or behavioral health (*with supervision from practicing physician*); or
- Clinical social workers (LMSW), working within their scope of practice, and qualified and experienced in diagnosing ASD.

QLPs should review how their ASD clinical experience fits the best practice guidelines outlined in this document. Further, QLPs whose clinical experience is not consistent with best practice standards should seek supervision for conducting evaluations. Supervision *must* be performed by a clinician with ASD clinical evaluation expertise, regardless of licensure type. The following should be considered for QLPs *before* conducting ASD evaluations:

- Do I meet the policy defined QLP criteria?
- Do I have the proper clinical experience with the full age and range of ASD per the Medicaid provider manual?
- Am I able to evaluate for common differential and comorbid neurodevelopmental conditions?
- If, by degree or training, I am limited in the range of tools I can utilize in my evaluations, do I have access to team members to whom I can refer to complete those portions of the evaluation when needed?

Scope of practice is defined as the procedures, actions, and processes an individual is permitted to perform based on professional licensure, training experiences, supervision, and demonstrated competence. Know your skill set and scope of practice! It is professional, respectable and the right clinical decision to refer to another clinician if the referral is out of your scope of competence.

While clinical social workers with experience in diagnosing ASD may be well-suited to complete portions of a comprehensive evaluation, some portions of the evaluation (e.g., cognitive assessment, assessment of certain comorbid conditions) fall outside of the scope of practice for LMSWs. Given the complex differential and comorbid nature of an ASD evaluation, LMSWs providing evaluations should do so as part of a multidisciplinary, team-based approach.

Evaluators should be experienced with the evaluation of ASD and associated conditions.

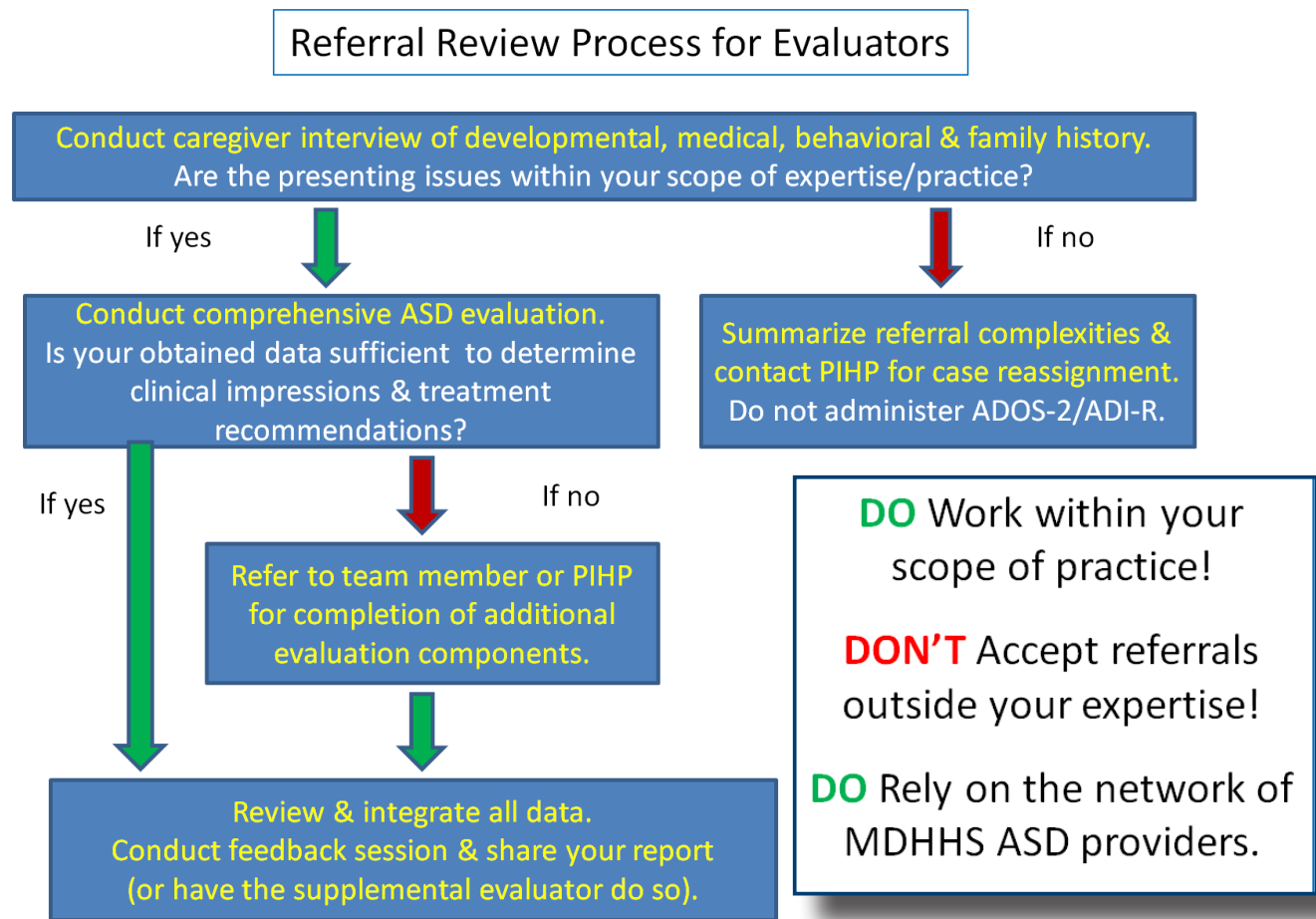
Successful ASD evaluators must show mastery of:

- Normal development ranging from birth through young adulthood.
- Full range of ASD evaluations and treatment planning.
- Comorbid and differential diagnosis of ASD (be a well-rounded clinician).
- When to seek consultation or support for difficult and/or unclear cases.
- The ability to work with other professionals who can provide other necessary components. (neurology, psychiatry, BCBA, speech/language or occupational therapy providers).

### ***Referral screening & follow-up consultation considerations***

PIHPs or regional CMHs will refer cases to QLPs for an ASD evaluation. Evaluators receiving referrals should ensure they are able to provide the needed assessment for that individual. Every case is unique and may require specific skills for an accurate and appropriate evaluation. Evaluators may need to request support or refer back to the PIHP/CMH when they are not able to accept the referral. To avoid possible bias and conflict of interest, QLPs should not conduct evaluations and provide treatment for the same individual. This does not mean that evaluations cannot be conducted by non-treating staff in the receiving or treating ABA agency. However, families should have choice of ABA providers following the evaluation. Further, the PIHP is responsible for reviewing the evaluations and determination of medical necessity to monitor for appropriateness of determination and recommendations.

Figure 2.1. The following flow chart should be considered by evaluators when receiving a referral:



### *Evaluator supervision requirements*

Evaluators are required to follow supervision guidelines outlined by their Michigan professional licensing board (see Appendix C for the Michigan rules for LLPs and TLLPs). Evaluators are also required to meet experience and supervision requirements for proper ASD diagnostic tool use. **Attendance at a two-day training workshop is not sufficient for new evaluators to perform evaluations without supervision from an experienced ASD evaluator.** The supervisor attestation form for LLP, TLLP, and PA credentialed evaluators for is found in Appendix D.

Evaluators are responsible for seeking appropriate supervision based on ASD evaluation skill needs and licensure requirements. Most clinicians new to ASD evaluation and the use of ASD evaluation tools will benefit from supervision from an ASD specialist, including clinicians who do not need supervision based on their licensure status. Appropriate clinical supervision is defined as an active process whereby a more senior or expert member of the same profession provides intervention to ensure appropriate practice, clinical care, and clinical skill building of a junior member or colleague (Bernard & Goodyear, 2009). Supervisors providing support for evaluators seeing individuals must have experience in ASD evaluation such that they are able to adequately provide clinical guidance to the evaluator. Notably, clinical supervision should be seen as distinct from agency or clinic related administrative supervision. In some regions or clinics, this may mean evaluators will need to have supervision with individuals outside of their agency/clinic. The use of telemedicine for supervision is allowed if adequate supervision is not available face to face.

Clinical supervisors should have ASD training and expertise; supervision should be an active process, not simply co-signing reports. Supervisors should be thoroughly discussing all cases with evaluators in which they are signing off on reports.

Administrators need to be aware that adequate clinical supervision by a professional with ASD experience is required and allow for this support for their evaluator(s). Administrators and evaluators should contact the local PIHP and the PIHP can contact other regions for the expertise needed for the child. MDHHS will only be contacted when the PIHP has not found a clinician within Michigan. The PIHP may also do a sole source contract with a clinician outside the PIHP system. *It is not acceptable for a child to not get a thorough evaluation due to a PIHP having a lack in expertise within the system.*

For evaluation purposes, the supervisor should routinely include the following in clinical supervision:	
Clinical Supervisors should do all of the following:	Clinical supervisors should do one or more of the following:
<p>Discuss/review cases:</p> <ul style="list-style-type: none"> <li>• Prior to the evaluation, including referral and assessment battery.</li> <li>• Following the evaluation, including history, data interpretation, and observational assessment.</li> <li>• Clinical diagnosis or diagnoses, formulation, and high priority recommendations.</li> <li>• Reports (and co-sign, as necessary)</li> <li>• <b>Note: it is not clinically appropriate to provide supervisor signatures for cases not discussed with the evaluator or seen by the supervisor. Reports should be thoroughly read and reviewed by the signing supervisor.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Actively participate in the evaluation process.</li> <li>• Actual observation of the individual being assessed.</li> <li>• Live or video-taped observation of ADOS-2 and/or interview.</li> </ul>

Administrators/chief clinical officers are encouraged to use a checklist to assure the supervisor has utilized one of the three appropriate supervision options listed

- ☐ Supervisor was part of evaluation process,
- ☐ Supervisor had direct observation of the child being assessed, or
- ☐ Supervisor used live or taped observation of a component of the evaluation in supervision).

The supervision process should be monitored by administrators using the supervision method form in Appendix F.

### ***Evaluator ongoing training & professional development***

To provide useful ASD evaluations, evaluators need to stay up-to-date with information regarding ASD evaluation, treatment, and management. Evaluators are encouraged to attend local, state, and national trainings, especially those related to best practice ASD evaluation. Given the shared features of ASD with several disorders and the high rates of comorbidity with other developmental and mental health conditions for children with ASD (Hartley et al, 2008; Stadnick, et al., 2015), training in differential and comorbid

diagnosis is strongly recommended. Evaluators are also strongly encouraged to attend booster trainings on ASD tool use (e.g., ADI-R and ADOS-2) to ensure that these standardized instruments are being used appropriately. Even well trained and highly experienced evaluators show drift in psychological assessment tool usage without recalibration (Groth-Marnat, 2009); as such, this recommendation for ongoing training should be seen as relevant to all evaluators, even those with extensive training and experience. Additionally, professional development and consultation with other ASD evaluators enhances the skill set of the entire network. The MDHHS Gov Delivery includes trainings and communication monthly. Evaluators are strongly encouraged to attend supported trainings in ASD evaluation. Ask your PIHP autism coordinator to add you to the MDHHS Autism GovDelivery newsletter and outreach communication.

It is an ethical responsibility for evaluators to engage in continuing education as required by licensure and clinical training need. Attendance at autism evaluation specific trainings is strongly encouraged. PIHPs and state professional associations are encouraged to support trainings in autism evaluation.



## Chapter 3.

### Comprehensive Diagnostic ASD Evaluations

#### *Michigan Medicaid Autism Services Evaluations*

It is the intent of the policy to provide a comprehensive, best practice evaluation for ASD. The goal of the evaluation process is to assist in determining the range of needs for the child being assessed. Simply determining a diagnosis of ASD does not provide information about what that child may or may not need for appropriate care and management. Access to Applied Behavior Analysis (ABA) treatment is only one component of a comprehensive evaluation and should not be the single intent for the assessment. Further, the evaluation diagnostic and needs assessment is intended to occur regardless of whether the child receives an ASD diagnosis. The goal is for the evaluation process to set the path to appropriate care and management for all individuals assessed.

A full range of current procedural terminology (CPT) codes have been approved for evaluator usage to cover comprehensive assessment. Evaluator credentials for CPT code usage must meet statewide license and billing guidelines within their scope of practice. See Appendix E for approved CPT codes, required credentials for code use, and sample CPT code use for diagnostic evaluations.

#### *Medical Necessity Criteria for ASD*

To meet medical necessity criteria, the individual must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction. Functional impairment may be defined by “the negative aspects of the interaction between an individual and that individual’s environmental and personal context” (WHO, 2010). Substantial impact could be observed in the individual’s adaptive skills, such as social, educational/occupational, and physical functioning. These deficits are evidenced by meeting criteria A and B (listed below):

For review, DSM-5 Symptoms of ASD (APA, 2013):

- A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:
  - 1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.
  - 2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.
  - 3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.
- B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:
  - 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).



2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).
4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).

Per the MDDHS Medicaid Provider Manual, the following requirements must also be met in order to enroll an individual in ABA services through the Michigan Medicaid Autism Services:

- Child is under 21 years of age.
- Child received a diagnosis of ASD from a QLP utilizing valid evaluation tools.
- Child is medically able to benefit from ABA treatment.
- Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the ABA interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social-communication, interactive play/age-appropriate leisure skills, reciprocal communication, etc.
- Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individualized Education Plan/Individualized Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).
- Services are able to be provided in the child's home and community, including centers/clinics.
- Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).
- Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.
- A qualified licensed practitioner recommends ABA services and the services are medically necessary for the child.
- Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.

### ***Essential components of a comprehensive ASD evaluation***

Before considering the essential components of the ASD evaluation, it is important to highlight the goals of the evaluation process. In the context evaluations, the goals generally include:

- Determination of accurate clinical diagnosis or diagnoses.
- Guiding treatment plans with all treatment recommendations based on results.
- Proof of medical necessity for access to care (e.g., ABA & other treatments and services).
- And, most importantly, to help the individual & family!



The most important goal of the ASD evaluation is to help the individual and family! Consider asking the caregiver questions, such as, “What would make life easier for you and your child?” and “What are you hoping will change for your child or family?”

**The first step in the assessment process is creating a team approach in which the family feels at the center in all aspects of the evaluation process, from the initial interview to the feedback session.**

The differential diagnosis of ASD and related conditions requires multimodal assessment and integration of clinical information. This is a complex assessment procedure in which clinicians must integrate data from caregiver report, records (e.g., medical, school, other evaluations), collateral reports (e.g., teachers, other treatment providers), data gathered from utilization of standardized psychological tools (e.g., developmental, cognitive, adaptive assessment), and the observational assessment to determine diagnostic and clinical impressions. The utilization of multiple data modes and sources improves the reliability of ASD diagnosis (Huerta & Lord, 2012). No one piece of data determines the ASD diagnosis, and evaluators should consider the accuracy of data and confounding factors that may impact data obtained (e.g., parent who seems to be overly negative about the child, child who was intensely shy during observational assessment).

Developmental, cognitive, adaptive, and language levels are needed to properly code and interpret data from the ADOS-2 and ADI-R. Specifically, many of the items must be interpreted based on the child’s nonverbal mental age (spatial and fluid reasoning skills)

or expressive language level. Knowing these skill levels generally requires direct assessment of skills (Gotham, Bishop & Lord, 2011). Testing, such as developmental or intellectual assessment, should be completed. It is difficult, if not impossible, for even highly experienced evaluators to guess or estimate the nonverbal mental age of a child without data. Per the ADOS-2 manual (Lord, et al., 2012; p. 6):

The ADOS-2 and ADI-R alone are not sufficient for a comprehensive evaluation of ASD.

*“Additionally, information about an individual’s cognitive and language abilities are necessary to interpret communications and social behaviors for the purpose of making a clinical diagnosis of ASD.”*

Moreover, the psychometric properties of the ASD diagnostic instruments (e.g., ADOS-2 & ADI-R) are based on tool use by evaluators with a high level of ASD experience and expertise who have obtained research level reliability with the measure (Lord, et al., 2012). While the tools are still useful with clinicians not reaching research reliability, especially in ASD and developmental assessment clinics, community-based utilization of these tools very likely results in less reliable administration, coding, and instrument classification based on the experience of the clinician (Kamp-Becker, et al, 2018). Thus, it is essential that evaluators take the time necessary with the caregivers and individual being assessed to form clinical judgments and use the tools properly, but not solely, to gain the data needed to make reasonable diagnostic impressions.

At a minimum, evaluators should have at least two hours of face-to-face time with the caregiver and child being assessed, including some time outside of ADOS-2 and ADI-R administration to allow for additional observation and clinical information gathering.

Evaluators should be spending at an absolute minimum two hours, but more routinely up to six hours of direct face-to-face time with the family and child being assessed. Following direct time, evaluators need several hours for scoring, record review, data interpretation, and report writing. This indirect time is essential for diagnostic accuracy and making the evaluation helpful to the family.

The use of a team approach with multiple evaluators having direct observation of the child being assessed may be useful and improve diagnostic reliability, especially for less experienced evaluators (Stadnick, et al, 2015, Daniels, et al, 2011). The evaluation team can be multidisciplinary. The evaluation team should be led by a highly experienced physician or licensed psychologist.

In some clinics, evaluation teams work on components of ASD evaluations simultaneously to reduce the time in clinic for families and to allow for multiple observers to assess the child. Other clinics have different evaluators who meet with families at separate appointment times, such as the ADOS-2 with one evaluator one day and speech and language assessment on another day. There are many excellent approaches to team evaluations for ASD.

Below is one possible example of a team assessment approach:

Evaluator #1	Evaluator #2
<ul style="list-style-type: none"> <li>Review referral, screening measure, and available medical &amp; educational records</li> <li>Discuss proposed evaluation battery</li> </ul>	
With caregiver(s): <ul style="list-style-type: none"> <li>Clinical interview</li> <li>Interview of ASD symptoms or ADI-R</li> <li>Adaptive behavior interview</li> </ul>	With child referred for ASD evaluation: <ul style="list-style-type: none"> <li>Developmental or cognitive evaluation</li> <li>Observations during direct testing</li> <li>Informal play observations</li> </ul>
<ul style="list-style-type: none"> <li>Both evaluators discuss appropriate ADOS-2 module based on data gathered</li> <li>One evaluator administers the ADOS-2 while the other evaluator observes</li> <li>ADOS-2 coded</li> <li>Both evaluators review all data and discuss clinical impressions and recommendations</li> </ul>	
<ul style="list-style-type: none"> <li>Follows up on any needed records or information</li> <li>Writes report</li> <li>Conducts feedback session with caregiver(s)</li> </ul>	<ul style="list-style-type: none"> <li>Provides written behavioral observations for inclusion in clinical report</li> </ul>

ASD evaluations are demanding and time-intensive. Evaluators should not be expected to complete multiple ASD evaluations per day, or the error rate in diagnosis will very likely increase.

Evaluators should consider conducting assessments at a developmentally appropriate time of day. For example, young children should not be assessed during routine nap times, and school-aged children may be fatigued following a full day of school. The data obtained from the assessment should be compared to what is reported to be typical for that child. Broad impressions should not be made on data that is not considered typical for the individual based on feedback by caregivers who know the child well.

There are many downsides of doing the bare minimum for diagnostic evaluations: over diagnosis, missed diagnosis, lack of response to treatment due to missed comorbidities, and poorly defined recommendations.

The following reflects the essential components to be covered:

Essential Components of ASD Evaluation for Michigan Medicaid Autism Services	
Caregiver Interview	<ul style="list-style-type: none"> <li>• Developmental &amp; medical history</li> <li>• Emotional and behavioral functioning</li> <li>• Family &amp; trauma/ACES history</li> <li>• ASD symptom history/ Autism Diagnostic Interview- Revised</li> </ul>
Record Review & Collateral Input	<ul style="list-style-type: none"> <li>• Medical providers</li> <li>• Other treatment providers</li> <li>• School/teachers</li> </ul>
Developmental/Cognitive & Adaptive Behavior Assessment	<ul style="list-style-type: none"> <li>• Developmental Disabilities- Children's Global Assessment Scale</li> <li>• Vineland Adaptive Behavior Scales or similar adaptive measure</li> <li>• Appropriate cognitive measure based on child's age and developmental level</li> </ul>
Observational Assessment	<ul style="list-style-type: none"> <li>• Autism Diagnostic Observation Schedule- 2nd Ed.</li> <li>• Clinical observations</li> </ul>
Integration of Clinical Information	<ul style="list-style-type: none"> <li>• Caregiver report</li> <li>• Records + collateral report</li> <li>• Developmental/cognitive &amp; adaptive behavior assessment</li> <li>• Observational assessment</li> </ul>

Diagnostic Conclusions & Recommendations	
Caregiver Feedback	<ul style="list-style-type: none"> <li>• Face to face feedback session</li> <li>• Clinical report with high priority recommendations</li> </ul>
Clinical Report	<ul style="list-style-type: none"> <li>• Clinical report with diagnostic impression(s) &amp; justification</li> <li>• High priority recommendations</li> <li>• Referrals</li> <li>• Resources</li> </ul>

## The Clinical Interview & Caregiver Report of ASD Developmental Symptom History

Interviews are used to gather caregiver reports on the child's current and past functioning. A clinical interview in addition to ASD specific interviewing is essential for differential and comorbid diagnosis of ASD, as well as for proper treatment planning. A clinical interview and interview of ASD symptom history (e.g., ADI-R or equivalent) are required. *Evaluators should be aware that the ADI-R (or SCQ) used in isolation does not meet this requirement.*

### *Clinical Interview*

The clinical interview is the foundation of assessment in all disciplines of mental health and allows clinicians to gather a great deal of historical and current information regarding a range of potential presenting and associated concerns (Gorgens, 2011; Somers-Flanagan, Zeleke & Hood, 2015). For the purpose of ASD evaluations, domains related to emotional-behavioral, medical, and family functioning should be covered in the clinical interview.

Domains to be covered in the clinical interview for ASD evaluations:

- Medical history (birth history, health status, medication use, seizures, head injury)
- Systems, including sleeping, eating, and toileting
- Developmental milestones and progress
- Previous & current evaluations/treatment
- Educational history & services
- Emotional & behavioral functioning
- Temperament
- Individual & family strengths (Sabapathy, et al, 2017)
- Caregiving situation (support, custody, neglect, abuse, estrangement, etc.)
- Individual/family stress & difficulties (Adverse Childhood Experiences, trauma, parental stress)
- Family psychiatric history

It is impossible to conduct differential and comorbid ASD evaluation without a thorough clinical interview.

### *ASD Symptom History Interview*

The caregiver ASD interview can be completed by 1) semi-structured tool use (e.g., ADI-R or other) or 2) by equivalent interviewing of current and ASD historical symptoms. Both methods are acceptable in combination with a clinical interview for evaluation. Given that ASD is a developmental disorder it is essential to obtain both current and historical information regarding ASD symptoms (APA, 2013; Shattuck, 2007). This means that evaluators will be interviewing caregivers about the child's social-behavioral presentation at the individual's present age *and* as a young child. Notably, a child's early presentation may be similar or quite different than their current presentation, so both time periods should be assessed in the interview.

## **Autism Diagnostic Interview-Revised (ADI-R)**

The ADI-R is a semi-structured interview designed to aid in the diagnosis of ASD. The tool is administered to caregivers of children suspected of having ASD. Use of the tool assumes the caregiver has robust knowledge of the child's current and past behavioral presentation and requires a mental age of around 18 months (Lord, et al., 1994). The evaluator must have experience with interviewing and working with children with ASD to be effective. The tool developers recommend users receive training or use the video training package prior to using the ADI-R clinically. Further, the tool should never be used in isolation for the diagnosis of ASD, but rather data from the ADI-R must be integrated with other clinical and observational data.

Done properly, the ADI-R generally takes around two hours to administer by experienced examiners (Lecouteur et al., 2003). The tool was developed to aid researchers in consistency in ASD diagnostic interview methods across research settings but has been successfully applied in clinical use (Lord et al, 1994; Zander et al., 2017). The tool has sound psychometric properties and interrater agreement when used by trained examiners (de Bilt et al, 2015; Lord et al., 1994). However, some studies suggest the tool may over-identify individuals who are severely and profoundly impaired (Nordin & Gillberg, 1998) and may be less accurate with very young children (de Bilt et al, 2015; Gray et al., 2008). The use of the ADI-R can be helpful in standardizing ASD interviewing, which may be particularly useful for less experienced evaluators, but proper use takes substantial time and may limit the time available for other data gathering during the ASD evaluation.

## **Interview of ASD Developmental Symptom History**

Please see the ASD Developmental Symptom History Interview handout, which covers the domains to address in the ASD interview in Appendix G and by hyperlink ([https://www.michigan.gov/documents/autism/Developmental\\_Symptom\\_History\\_Interview\\_Best\\_Practice\\_638467\\_7.pdf](https://www.michigan.gov/documents/autism/Developmental_Symptom_History_Interview_Best_Practice_638467_7.pdf)).

## **General limitations of interview data**

Caregivers often provide a wealth of information on the child being assessed. However, as with all assessment modes, there are limitations to caregiver interview data whether collected by a semi-structured tool or an open interview. There are several potential limitations to interview data for ASD diagnosis, such as the caregiver having insufficient information on the child (this is addressed in the section on factors that complicate ASD evaluation), caregiver comprehension deficits (e.g., caregiver with intellectual disability), and caregiver reporting bias. Successful interviews with caregivers with intellectual disability are possible with appropriate considerations and techniques (Hollomotz, 2017).

Tips for interviewing caregivers with Intellectual Disability:

- Be patient and allow adequate time for the interview
- Allow time for processing and do not seem rushed or hurried
- Treat the caregiver respectfully (age-appropriately) and not in a child-like manner
- Keep language simple and clear
- Avoid using technical jargon (this tip applies for all families!)
- Assess for comprehension of questions
- Avoid using multi-part questions
- Know the caregiver may be more susceptible to recency effects in responding
- Ask the caregiver to share stories that may help to elicit information regarding the behaviors being investigated (e.g., what does [child's name] do when at the park?)
- Be cautious of caregivers who may be overly agreeable or wish to please the examiner by answering yes to many questions

- Be aware the caregiver may be sensitive to answering questions that they perceive as showing parenting behaviors in a negative light due to fear of the child being taken away; this is a real fear, as parents with ID disproportionately have children removed despite supports that are effective at addressing caregiving concerns (Booth, Booth & McConnell, 2005; Tarleton, Ward & Howarth, 2006)

Caregiver bias in reporting is a common difficulty encountered by ASD evaluators. Caregivers can over-report or under-report ASD symptoms, both of which cause challenges in data interpretation and the assessment process. It is often useful in both circumstances to start with broad open-ended questions and then use more symptom specific questions as needed. Additionally, when it is clear that there may be caregiver reporting bias, it can be helpful to partner with the caregiver to determine and clarify the goal of the evaluation and how the data you are gathering will help to meet that goal.

As noted, interview data should never be used in isolation in making an ASD diagnosis. Supporting this point, there is robust data showing that the combination of ASD interview and observational data results in better ASD diagnostic accuracy and should be the standard of care; further, of the two assessment methods, the observational assessment for ASD demonstrates better diagnostic accuracy than interview data (Zander et al, 2014) and is less susceptible to parental concern (Havdahl et al, 2017).

Collateral reports from teachers and other treatment providers are particularly important when interview and observational data differ.

## **Collateral Input & Record Review**

It is important for examiners to gather input and relevant records from school, medical, and other ancillary treatment providers. Collateral input and review of records helps to ensure that no major information that could impact clinical impressions and recommendations will be missed. Further, record review provides additional input about the child in different contexts and/or by other reporters who know the child. It is particularly important to obtain teacher input (e.g., interview, rating scales, written observations) for school-aged children as this provides information about behavior in the peer social context. If the individual is receiving ABA services, review ABA assessments, progress, and response to treatment; ideally, the BCBA should partner with the evaluation team to provide collaborative input.

*Records and collateral information should be obtained before diagnostic and treatment recommendations are formulated.*

## **Observational Assessment**

Observational assessment is a core component and should always be included in the evaluation of ASD (Gotham, Bishop & Lord, 2011; Zander et al, 2014). It is important to note that observational assessment is essential even when the ADOS-2 cannot be used for coding or classification (some of these instances are reviewed under factors that complicate ASD evaluation).

ASD is a heterogeneous condition with a wide range of presentations; thus, evaluators must be familiar with the full range of ASD presentations from highly verbal, socially interested individuals to those who are nonverbal and lack social responsivity.

## ***Unstructured (Informal) Observations***

A range of observations in different context and situational demands is useful for ASD evaluation. Evaluators are encouraged to incorporate clinical observations, including those seen outside of the semi-



structured observational assessment, into the overall clinical formulation. Observations without structure or probes provide a useful sample of typical behaviors and interests and should be included in addition to the semi-structured observational assessment (Goldstein & Ozonoff, 2018). Unstructured observations can be gathered at any time, including the waiting room, walking to the testing room, break time during testing, down time between the individual and caregiver, etc. Further, some caregivers may wish to share home videos depicting notable behaviors. All of these observations are helpful for the overall clinical impression.

The value of the observational assessment is based on the evaluator's ability to detect the full range of ASD signs and symptoms; this takes a great deal of practice and experience. New evaluators who have only been through the two-day workshop on the ADOS-2 will require additional practice, training, and supervision to use the tool properly and ethically.

### ***Autism Diagnostic Observation Schedule- Second Edition (ADOS-2)***

The ADOS-2 is a required component of the ASD evaluation and should be utilized and scored whenever the individual falls within the scope of the standardization sample (notable exceptions are discussed in the differential and special populations sections of this guideline). While highly useful data, the ADOS-2 is intended to be only one component of the comprehensive ASD evaluation and should never be used in isolation, but rather utilized as part of an integrated assessment with multiple domains and sources (ADOS-2 manual; Lord et al., 2012). The ADOS-2 should be used as it was standardized *in a clinic-based setting* and not at the family's home; while home-based observations can be a useful component of ASD evaluation in some cases, the clinical tools should be administered in a clinic-based setting.

Moreover, ADOS-2 algorithm cutoffs determine instrument classification and not diagnosis; diagnosis should always be based on integrated clinical judgment and not the score on a measure or even a combination of measures (Gotham, Bishop, & Lord, 2011).

As noted in the ADOS-2 manual (Lord et al., 2012; p. 5-6) and by the test publishers (WPS ADOS-2 FAQ website; please see <https://www.wpspublish.com/app/OtherServices/FAQs.aspx#FAQ=0>), the ADOS-2 should be used by evaluators who:

- have prior experience with individualized testing,
- “extensive exposure to ASD,”
- received proper workshop and/or video package training on administration and coding of the ADOS-2 and have studied the ADOS-2 manual,
- had additional exposure to tool use outside of formal diagnostic evaluations and the ADOS-2 workshop to allow for “complete familiarity with the assessment activities and complete confidence that they can apply the coding categories accurately;”
- had additional practice exposure outside of diagnostic evaluations as defined by “as few as 10 practice sessions (2 per module)” for evaluators with “considerable experience in formal behavioral observation and individual test administration; for those with less experience, evaluators “may need considerably more practice to obtain competence in administering and coding the ADOS-2;” and
- are using the tool within their experience, scope of practice, and professional credentials.

Use of the ADOS-2 alone is not sufficient for a comprehensive evaluation and should never be used without multiple other assessment components.

One challenge of the ADOS-2 can be proper module selection. Module selection should be based on:

- First, the child's expressive language level, and
- Secondly, the child's age.

According to the ADOS-2 publisher and test developers, the two-day workshop on the ADOS-2 is intended to provide basic training and familiarity on administration and scoring of the tool for those with prior extensive experience with ASD. The ADOS-2 workshop is specific to tool use and is not intended to be a comprehensive training in clinical ASD evaluation.

Evaluators should use obtained language data from direct language evaluation or the adaptive behavior measure to have an initial determination of the correct module; please see page 12 of the ADOS-2 manual for suggested expressive language level equivalent age cut suggestions. However, evaluators are reminded to base module selection on the language uttered during the course of the ADOS-2 administration, even if language levels differed at other times (coding of item A1). *Notably, using the incorrect module results in a substantially higher rate of misclassification* (Lord et al., 2012).

Although a required and valuable component of ASD evaluation, the ADOS-2 has some limitations of which evaluators should be aware. First, there are notable populations for which the tool cannot be utilized based on lack of inclusion in the standardization sample. This includes individuals with mobility issues (must be ambulatory) and sensory (vision and hearing) impairments. Additionally, there are some clinical presentations that may impact the individual's performance and presentation in the ADOS-2, such as children with severe anxiety or selective mutism who have variable social presentations, young children with severe trauma and attachment histories, and children with extreme behavioral conduct. Other individual variable factors, such as illness and lack of sleep, may impact performance in an observational assessment. There is also some data that the ADOS-2 may not allow for adequate expressions of restrictive and repetitive behaviors (RRBs), especially in Modules 3 and 4 (Kuhfeld & Sturm, 2018). Finally, it is important to note that the ADOS-2 has adequate psychometric properties, but, as with all assessment measures, results in both false positive and false negative classifications, even when the tool is used by highly experienced (i.e., research reliable) evaluators. These factors again highlight the need to use the obtained observational data in combination with multiple modes and sources of information.

### **Assessment of developmental, cognitive & language functioning**

Given that ASD is a neurodevelopmental disorder, it is essential to understand the developmental, cognitive, and language functioning of the child to properly interpret the social communication and interaction behaviors exhibited during the evaluation. Further, this information guides programming, intervention decisions, and future planning. Direct assessment of developmental, cognitive, and language skills is strongly recommended. Language assessment can be conducted as part of the evaluation process, including language components embedded in developmental and cognitive measures and/or through formal measures of speech and language skills. Comprehensive speech and language evaluation can also be suggested as part of the evaluation recommendations when not completed, but clinically warranted.

The ADOS-2 cannot be used in a standardized manner or scored for individuals who are non-ambulatory or who have vision or hearing impairment.



Cognitive skills are more variable in individuals with ASD than in the general population (Courchesne et al, 2018; Joseph et al, 2002; Mandy et al, 2015; Oliveras-Rentas et al, 2012). Determination of cognitive ability requires ongoing evaluation of cognitive skills until multiple assessments suggest consistency in the child's cognitive profile. Despite a high portion of individuals with ASD presenting with language impairments, many individuals have intact nonverbal intellectual skills (Fombonne, 2005). Therefore, cognitive skills should be assessed by domain and not only globally. Further, there is some evidence that commonly used tools, such as the Wechsler intelligence scales, may underestimate intelligence for children with ASD (Nadar et al, 2014). Evaluators should have experience with a range of cognitive measures for children with ASD, including assessment for those who are nonverbal, if accepting such referrals.

Knowledge of the child's nonverbal mental status and expressive language level is necessary for proper coding of the ADOS-2.

Young children are often more difficult to assess than older children, teens, and adults. Assessment can be particularly challenging for young children suspected of having ASD. Experience with standardized assessment of young children is essential for ASD evaluators. The use of positive behavioral management skills (e.g., when to use praise, active ignoring, etc.) and a flexible approach (e.g., use of breaks, seating modifications, etc.) within the bounds of the standardized instrument are helpful skills for evaluators to have and use when evaluating young children (Courchesne et al, 2018). Despite some challenges, there is great value in having baseline developmental/cognitive information and completing tracking or ongoing assessment of developmental skills. Firstly, both expressive language level and nonverbal IQ are strong predictors of response to early intensive behavioral intervention. Secondly, early intensive behavioral intervention is associated with gains in developmental and cognitive skills (Eldevik, 2009; Howlin et al, 2009); assessment of these skills in a standardized manner documents treatment gains. Given the variability in skills and potential for improvement in response to intervention, baseline assessments of young children should not be used for long-term intervention planning.

Cognitive or developmental evaluation should be strongly considered in the following circumstances:

- The child has never had cognitive testing completed
- The child has not had recent (within the last year) cognitive testing
- The child has not shown consistency in cognitive skills in two previous assessments
- The child's cognitive skills have been variable across previous assessments
- One or more of the following conditions are suspected:
  - Developmental delay
  - Intellectual disability
  - Language disorder
  - Learning disorder
  - Giftedness
  - Other comorbid condition requiring further assessment

## **Adaptive Functioning**

Adaptive functioning refers to an individual's day-to-day use of skills across a range of domains for personal and social self-sufficiency in life. Children with ASD often struggle with using their skills to function adaptively in life. Discrepancy between cognitive skills and adaptive behaviors are evident from toddlerhood through adulthood in individuals with ASD and often become more pronounced with age (Jacobson & Ackerman, 1990). Adaptive behavior deficits are seen in individuals with ASD who have intact intellectual skills (Kenworthy et al., 2010). The most pronounced deficits for individuals with ASD are typically seen in the communication and socialization domains (Ventola et al., 2007; Ray-Subramanian et

al., 2011). Understanding the child’s adaptive behavior profile is helpful in differential diagnosis (Mossman Steiner et al, 2012) and often crucial to effective intervention planning. Thus, adaptive behavior assessment is a key element in autism evaluation.

Assessment of adaptive functioning helps to determine the “substantial functional impairment” requirement for medical necessity

**Caregiver Report of Adaptive Behavior:** There are many tools developed to assess adaptive behavior (please see Table X for a review of adaptive behavior assessment tools). Tools that allow for semi-structured caregiver interviewing, such as the Vineland Adaptive Behavior Scales (Sparrow et al., 2016) may be seen as the gold standard for adaptive behavior assessment (Mossman Steiner et al, 2012). Interview methods should always be used to obtain adaptive behavior when there are concerns regarding caregiver over- or under-reporting, caregiver comprehension, and/or caregiver reading ability.

**Clinician Assessment of Adaptive Behavior:** Additionally, the Developmental Disabilities Children’s Global Assessment Scale (DD-CGAS; Wagner et al., 2007) is a required tool that provides clinician assessment of the individual’s overall adaptive behavior and is anchored to domains that are often weak for children with ASD. On the DD-CGAS, clinicians are asked to rate the level of functional interference for the following domains: a) self-care, b) communication, c) social behavior, and d) school/academic performance and then to select the descriptive category and score that best reflects the summary of the child’s current functioning. The DD-CGAS can be a useful measure to capture gains in adaptive behavior through intervention when assessing over time.

Figure 3.1. Measures for assessing caregiver report of adaptive behavior in individuals with ASD.

Measure	Age Range	Format/Time	Skill Domains Assessed
Vineland Adaptive Behavior Scales (VABS-3; Sparrow et al., 2016)	Birth to 90 years	Interview or parent rating form  20 to 90 minutes	<ul style="list-style-type: none"> <li>● Communication</li> <li>● Daily living</li> <li>● Socialization</li> <li>● Motor</li> </ul>
Scales of Independent Behavior-Revised (SIB-R; Bruininks et al., 1996)	Birth to 80+ years	Interview or parent rating form  15 to 60 minutes	<ul style="list-style-type: none"> <li>● Social interaction &amp; communication</li> <li>● Personal living</li> <li>● Community living</li> <li>● Motor</li> </ul>
Adaptive Behavior Assessment System (ABAS-3; Harrison & Oakland, 2015)	Birth to 89 years	Parent, teacher & caregiver rating forms  15 to 20 minutes	<ul style="list-style-type: none"> <li>● Conceptual</li> <li>● Social</li> <li>● Practical</li> </ul>
Diagnostic Adaptive Behavior Scale (DABS; Tasse et al., 2017)	4 to 21 years	Interview  30 minutes	<ul style="list-style-type: none"> <li>● Conceptual</li> <li>● Social</li> <li>● Practical</li> </ul>

## Medical Assessment & Referral

Medical assessment of children with suspected ASD and related conditions is considered a component of best practice evaluation. Ongoing routine pediatric care is essential; this includes well child visit assessments, lead screening, vision and hearing evaluation, and following the AAP and CDC recommended vaccination schedule (see Appendix H for the CDC handouts on the recommended 0 to 6 and 7 to 18 vaccination schedules). As ASD specialists, evaluators are responsible for debunking commonly held misconceptions regarding ASD and vaccinations for the benefit of the child and public health. Based on a large body of research and determination by multiple medical organizations, it is known and accepted by the medical community that there is no connection between ASD and vaccination (Taylor, Swerdfeger, & Eslick, 2014; Jain et al., 2015; DeStefano, Bhasin, Thompson, Yeargin-Allsopp, & Boyle, 2004; CDC, 2015).

While full medical assessment is often outside the scope of evaluations completed for determining medical necessity, referral for assessment by medical specialty providers is strongly recommended based on information obtained in the clinical interview. Given the increased rates of a range of medical conditions for children with ASD and associated conditions, including epilepsy/ seizure disorders, gastrointestinal problems, allergy and immune system anomalies, and sleep problems (Amaral et al, 2011), the following should be considered for medical specialty referral as clinically indicated based on the child's presenting signs and symptoms:

- Neurology
- Gastroenterology
- Allergy/immunology

Finally, individuals with ASD have increased rates of other mental health comorbidities, while there is no medication that targets the core features of ASD, individuals may require medical management of mental health comorbidities and/or associated aggression and agitation. In such cases, referral for psychiatric evaluation by a provider with expertise in the management of ASD and other neurodevelopmental conditions is warranted.

### *Assessment considerations by age & development*

Autism Spectrum Disorder is a neurodevelopmental condition. As such, ASD impacts development, and development impacts the expression of ASD (Amaral et al, 2011; Xiao et al, 2014). This means that developmental considerations are a central tenet of ASD evaluation. The developmental status, age, and functional level of the child should guide the evaluator in proper tool selection and use. Particular attention should be given to:

- Obtaining data that determines what the child can do (strengths-based approach), not just deficits.
- Utilizing tools that have lower language demands for children with language impairment.

Please review the handout on ASD Assessment by Age Best Practice for suggested batteries and considerations by age and functional status; see Appendix I.

Children with neurodevelopmental disorders often show disruptions in language, play skills, and peer relationships (e.g., due to not having the language or ability to play in the same way). An ASD diagnosis should encompass more than just social delay and consider the child's overall presentation.

## ***Comorbid & differential diagnosis***

The presentations of individuals referred for ASD evaluations in the community mental health setting are highly variable with a range of conditions that should be considered for differential and comorbid diagnosis. ASD shares a high number of features with other conditions, and individuals with ASD have increased rates of comorbidity with other neurodevelopmental and mental health conditions (Hartley, et al, 2008; Simonoff et al., 2008; Stadnick, et al, 2015). Differential and comorbid assessment is essential for accurate diagnosis and intervention planning, with particularly unique needs for those on the autism spectrum (Brookman-Frazee, et al, 2012).

The following are frequent differential and comorbid conditions with ASD:

- Language Disorder
- Developmental Delay
- Intellectual Disability
- Attention Deficit/Hyperactivity Disorder
- Anxiety Disorders
- Depressive Disorders
- Trauma & Attachment Disorders
- Psychotic Disorders
- Visual & Auditory Sensory Impairments

Not all children with speech and language delays will meet criteria for ASD. Language impairment alone does not warrant an ASD diagnosis.

### **Language Disorder**

Language disorder is characterized by difficulties with language comprehension and/or production (APA, 2013). Language disorders can affect children socially (e.g., communication deficits can hinder peer interactions), academically (e.g., understanding of directions and use of language in the classroom and in written work), and adaptively (e.g., functional use of language for day-to-day life). Language disorder is a common co-occurring condition with ASD. Language disorder is also a common differential condition, especially in early childhood ASD evaluation, and developmental language disorder is often seen for children failing the M-CHAT but not ultimately receiving a diagnosis of ASD (Ventola, 2007; Eaves et al., 2006).

Young children with language disorder share common characteristics of young children with ASD, including some social impairment with peers (usually consistent with language level) and sensory/restricted and repetitive behaviors (Lord et al., 1993), though generally not to the same degree of impairment level of children with ASD (Rogers et al., 2003).

Children with ASD often have a discrepancy between obtained language skills and adaptive communication use. Further, nonverbal communication deficits, such as weak gesture use, are characteristic of ASD, but not of Language Disorder (Mitchell et al., 2006). Children with ASD are also more likely to display echolalia and stereotyped language use (Landry et al., 1988) and less likely to initiate or respond to spoken communication than children with language disorder (Lord et al., 1994).

### **Assessment considerations for Language Disorder**

- Assess receptive and expressive language skills and speech articulation or refer for a comprehensive speech and language evaluation.
- Assess social use of language.
- Look for nonverbal compensation for language deficits (e.g., gestures, pointing, etc.).
- Compare social behaviors relative to developmental/language level.

## Developmental Delay

Developmental delay (DD) is defined by lag in expected skill development in any to all of the domains of motor, cognitive, communication, social or emotional development, and adaptive development. Generally, the DD designation is used to capture delays in early childhood development, such as children under the age of 5 (APA, 2013). Autism falls in the continuum of developmental delay, and young children with ASD can present with focal or global delays in development.

There is a high rate of shared features in young children with ASD and those without ASD who present with developmental delays (Ventola et al., 2007). Many children with developmental delay have *some* of the characteristic social deficits seen in children with ASD (Charman et al., 1998). Further, many young children with developmental delay present with sensory and/or restricted and repetitive behaviors; however, children with ASD tend to have higher levels of and more impairment from these behaviors (Boyd et al., 2010). These shared features can result in children with DD failing ASD screening instruments (Ventola et al., 2007), as well as difficulty with differential diagnosis, especially in the absence of developmental and adaptive assessment data with which to make comparative developmental references. Nevertheless, DD can be reliably distinguished from early childhood ASD, with the most notable differences being in the gap between the child's developmental status and social development, with children with ASD generally showing a larger gap between their general developmental status and social development. In particular, children with ASD tend to demonstrate flat or declining social trajectories, more impairment in shared gaze, expression, and enjoyment (Mitchell et al., 2011) and joint attention behaviors (Ventola et al., 2007) relative to children with global DD.

Most young children who have a positive screen for ASD symptoms and are referred for an autism evaluation will show some developmental or language delay. Evaluators should assess and recommend appropriate early intervention for children without ASD who present with developmental delays.

### Assessment considerations for DD

- Developmental evaluation (e.g., Mullen Scales of Early Learning, Bayley Scales of Infant Development).
- Adaptive behavior assessment.
- Compare social behaviors relative to developmental level.
- Examine joint attention behaviors and shared enjoyment.

## Intellectual Disability

The diagnosis of Intellectual Disability (ID) requires deficits in cognitive skills and adaptive behaviors that are present during the developmental period (APA, 2013). Approximately 25 to 50% of individuals with ASD also have Intellectual Disability (CDC, 2018; CDC, 2012). Adaptive deficits are hallmarks of both ID and ASD, including individuals with ASD without ID. Children with ID have deficits in social behaviors and communication skills, as also seen in ASD; however, the deficits in these domains are generally commensurate with the child's cognitive or developmental level for ID, whereas there is often a marked discrepancy for ASD between the child's cognitive or developmental level and social and communicative behaviors. For example, a 10-year-old child with an intellectual disability who is functioning at a 4-year-old developmental level should show social and play behaviors typical of that seen for children around the age of 4. Further, individuals with ID show sensory and restricted and repetitive behaviors, especially as the severity of the ID increases (Hattier et al., 2011; Oliver et al., 2011), though with less impairment than is typically seen for individuals with ASD. Additionally, individuals with ASD have substantially higher rates of comorbid mental health conditions, which should be taken into consideration in the evaluation process (Brereton et al., 2006).



The differential diagnosis of ID and ASD can be complex and requires cognitive assessment to determine the level of intellectual impairment for comparison with social behaviors. The use of interview and observational assessment is effective at differentiating ASD from ID at mild and moderate levels (de Bilt, 2004; Sappok et al., 2013) when the level of cognitive impairment is taken into consideration. However, the ADOS-2 has less specificity (more false positives) with severe and profound ID (Berument, 2005; de Bilt, 2004; Sappok et al., 2013).

#### Assessment considerations for ID

- Intellectual evaluation.
- Adaptive behavior assessment.
- Compare social behaviors relative to cognitive level.
- Utilize interview information and unstructured observations regarding social behaviors.
- Attend to social interest and sharing.

#### **Attention Deficit/Hyperactivity Disorder**

Attention Deficit/Hyperactivity Disorder (ADHD) is a common childhood disorder, impacting up to 8% of children (American Academy of Pediatrics, 2011) and is comprised of deficits with focus, activity level, and impulsivity that impact day to day functioning (APA, 2013). It is widely accepted that ADHD and ASD co-occur with high frequency, with up to 40 to 60% of individuals with ASD also meeting criteria for ADHD (Goldstein, 2004; Lee, 2006; Sikora, 2011). The comorbid diagnosis of ADHD and ASD should be made only when the ADHD-related deficits exceed that of the comparable developmental level of the child (APA, 2013). For example, if an 8-year-old child is functioning at the cognitive level of a 4-year-old, the ADHD symptoms should exceed those that are typical for a 4-year-old child.

Given that children with ADHD have variable attention and sometimes demonstrate sensory processing and social deficits, the differential diagnosis of ASD and ADHD can be difficult. Many children with both ASD and ADHD are first diagnosed with ADHD with a resulting delay of up to three years in the comorbid ASD diagnosis; as such, the presence of ADHD can overshadow the ASD features, especially in early childhood (Miodovnik, 2015). Thus, given the high rate of comorbidity, evaluators should ensure to fully investigate ASD even in the presence of evident early childhood ADHD. Importantly, though children diagnosed with ADHD without ASD display social deficits, the nature of these deficits is generally due to executive and impulse regulation difficulties (social performance deficit) as compared to the core social skill deficits seen in children diagnosed with ASD.

#### Assessment considerations for ADHD

- Obtain collateral parent and teacher reports of ADHD symptoms (interview, rating scales).
- Examine the impact of attention and impulse control deficits in a developmental context relative to the child's mental age.
- Assess for skill versus performance deficits in social behaviors.
- Attend to social sharing and enjoyment.

ASD and ADHD co-occur 40 to 60% of the time.

#### **Anxiety Disorders**

Anxiety disorders are generally defined by combined features of persistent and excessive fear, worry, and avoidance behaviors (APA, 2013). Anxiety disorders, especially those with social anxiety features, such as selective mutism, can be challenging to differentiate in the observational assessment due to the inherent social demands of the situation. In these situations, it is essential to rely on caregiver and other informant reports to determine the variability of social presentations for the child in multiple settings. While children

with anxiety exhibit better social behaviors in comfortable situations with familiar others, children with ASD will exhibit social difficulties persistently across settings.

However, it is essential to highlight that Anxiety and ASD frequently co-occur, with up to 40% of individuals with ASD presenting with a comorbid anxiety disorder (Simonoff et al., 2008) with notable increases in anxiety seen for adolescents on the spectrum (Bellini, 2006). Self-report of anxiety can be complicated in individuals with ASD due to difficulty with introspection (Capps, 1992; Gillott, 2001). Further, children and teens with ASD and clinical anxiety may not show age-typical anxiety symptoms (greater behavioral presentation); the use of multiple reporters and methods (e.g., rating scales, interview, observation) is recommended to offset reporting difficulties and variance in anxiety presentation (White et al., 2009).

ASD and anxiety co-occur up to 40% of the time, with high rates in individuals with ASD who have intact intellectual skills.

#### Assessment considerations for Anxiety Disorders

- Obtain self and collateral parent and teacher reports of anxiety, social behaviors, and ASD symptoms.
- Attend to social sharing and enjoyment in comfortable situations and with comfortable others.
- Be aware of the high co-occurrence of ASD and anxiety disorders.
- Use multiple informants and methods to assess anxiety in individuals with ASD.

#### **Depressive Disorders**

Depression in children and teens is exhibited by multiple symptoms, including sadness, irritability, changes in sleeping and eating habits, and feelings of inadequacy, guilt, and hopelessness (APA, 2013). There are some symptom features shared by ASD and depression; depression can result in lack of social enjoyment and responsiveness, social withdrawal, as well as muted affect. The differential diagnosis of depression versus ASD requires a thorough developmental history, multiple informant reports, and examination of symptom onset and trajectory. While mood symptoms can wax and wane, ASD is a chronic neurodevelopmental condition; thus, assessment of the onset and trajectory of symptoms may be useful in this regard. Further, sleeping and eating issues are common for individuals with ASD so the focus for differential and comorbid assessment should be on change in these behaviors rather than the presence of such difficulties.

Depression rates for children with and without ASD are reported to be broadly similar, impacting about 2 to 4% of children (Ghandour et al., 2018; Magnuson & Constantino, 2011). However, the rates of depression in adolescents with ASD are substantially higher (8% in teens without ASD compared to up to 20% of teens with ASD), especially among teens with intact intellectual skills and medical comorbidities (Greenlee et al., 2016; Magnuson & Constantino, 2011).

One complication in the assessment of depression in children and teens with ASD is difficulty with self-reporting emotional states. Some studies have suggested reasonable reporting of depressive symptoms in verbal teens and adults with ASD (Gotham et al., 2015), though other studies note older children and teens with ASD may under-report depressive symptoms (Mazefsky et al., 2011). Nevertheless, parents often struggle to report on the internal emotional states of children and teens (Messman & Koot, 2000; Moretti et al., 1985), and this difficulty may be especially marked in higher functioning teens with ASD (Hurtig et al., 2009). Presently, there is no data to suggest that informant reports are better measures of emotional functioning in children and teens with ASD (Gotham et al., 2015).

Children with anxiety and/or depression may appear withdrawn or may not play with other children due to mood disruption or fears. This can interfere with social functioning and peer relationships.



When there is concern about depression in an individual with ASD, self-report of emotional functioning should be obtained. However, self-reports should be interpreted with caution due to possible under-reporting when there is discrepancy with other assessment methods and informant reports suggesting depressive symptoms.

### Assessment considerations for Depressive Disorders

- Obtain self, parent, and teacher reports of mood, social behaviors, and ASD symptoms.
- Use interviews in addition to self-report scales.
- Pay careful attention to symptom onset and trajectory.
- Be aware of the high co-occurrence of ASD and depression for teens with ASD and intact intellectual skills.
- Know that under-reporting of depression may occur for individuals with ASD and/or parents may not be aware of or report internalizing conditions in their children and teens with ASD.

### **Trauma & Attachment Disorder**

Children with ASD are 1.5 to 3 times more likely to experience traumatic events than typically developing peers and are more likely to present with trauma sequelae (Kerns et al., 2015; Haruvi-Lamdan et al., 2018). Trauma experiences can be related to maltreatment, death and separation from loved ones, exposure to home or community violence, bullying/peer victimization, disasters, and painful medical interventions (National Child Traumatic Stress Network, 2012). Trauma symptoms, particularly in early childhood, share some symptom overlap with ASD symptoms. Both conditions can result in delayed development, dysregulated social behaviors, avoidance/fears, repetitive play, and emotional and behavioral symptoms. The differential diagnosis of ASD and early childhood trauma can be complex. Factors to consider include the experience of traumatic events, consistency of observed deficits, and the onset and trajectory of symptoms.

The following figure may be useful in understanding where symptoms converge and diverge for ASD and trauma/PTSD (Stavropoulos et al., 2018):

Figure 3.2. ASD and Trauma Symptom Overlap

<b>Autism Spectrum Disorder</b>	<b>Overlap</b>	<b>Post-Traumatic Stress Disorder</b>
Deficits in social-emotional reciprocity	Lack of interest in peers	Social withdrawal
Deficits in social communication	Failure to share emotions/affect	Reduction of positive emotions
Repetitive use of objects	Repetitive Play	Intrusive memories
Inflexible adherence to routines/insistence on sameness	Outbursts	Irritability/Anger
Associated feature of Autism Spectrum Disorder	Sleep difficulty	Recurrent nightmares/difficulty falling or staying asleep

Children with ASD may be especially prone to the experience of peer and caregiver maltreatment and may be more prone to show trauma symptoms following such experiences (Hoover, 2015). The presentation of trauma symptoms in children with ASD may vary from classic PTSD presentations. The following are suggested hallmarks of trauma symptoms in a child with ASD:

- Increased emotional reactivity.
- Worsening of behavioral symptoms.
- Worsening of ASD symptoms and social avoidance.
- May be less likely to report, seek help, or talk about the trauma.

Relatedly, Attachment Disorders are used to characterize the presentation of children who develop deviant attachment behaviors related to inadequate, unstable, or abusive caregiving (APA, 2013). There are two subtypes of presentations of attachment disorders: emotionally withdrawn inhibited type and indiscriminately social/disinhibited type. Most of the available research examines what is now called Disinhibited Social Engagement Disorder (previously called RAD Disinhibited Type prior to the DSM-5), in which the symptoms include disinhibited social interactions and indiscriminate sociability. There are common shared features of Disinhibited Social Engagement Disorder and ASD, as well as differences in presentations (Davidson et al., 2015), which are depicted in Table X. Given that children with ASD may be more likely to experience caregiver maltreatment and disruption, the comorbid presentation of ASD and Disinhibited Social Engagement Disorder can exist (Mayes et al., 2017) and should also be considered.

Figure 3.3. Possible similarities and differences between Disinhibited Social Engagement Disorder and ASD.

Possible Similarities	Possible Differences
<ul style="list-style-type: none"> <li>● Inconsistent social behavior</li> <li>● Inappropriate social behaviors</li> <li>● Poor social boundaries</li> <li>● Weak eye contact</li> <li>● Pragmatic language deficits</li> <li>● Emotional reactivity</li> <li>● Perseveration</li> </ul>	<ul style="list-style-type: none"> <li>● Early childhood history</li> <li>● Trajectory of symptoms</li> <li>● Indiscriminate sociability/affection (RAD)</li> <li>● Stereotyped language (ASD)</li> <li>● Quality of social behavior (RAD &gt; ASD)</li> <li>● Directed enjoyment (RAD &gt; ASD)</li> <li>● &gt; Attention seeking (RAD)</li> <li>● &gt; Reciprocal communication &amp; conversational skills (RAD)</li> </ul>

### **Assessment considerations for Trauma & Attachment Disorders**

- Interview caregivers and individuals about the experience of trauma and expression of traumatic stress.
- Pay careful attention to symptom onset and trajectory.
- Know the differences in expression of attachment disorders and ASD that may occur in an observational assessment.
- Be aware that ASD and attachment disorders can co-occur.
- Evaluators seeing young children referred for ASD evaluations who have experienced caregiving disruptions and/or trauma should be highly experienced in the evaluation of both conditions.

### **Psychotic Disorders**

Psychotic Disorders comprise a mix of affective (e.g., bipolar disorder, schizoaffective disorder) and non-affective (e.g., schizophrenia, transient psychotic disorder) thought disorders. Symptoms of psychosis include delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, and negative symptoms (APA, 2013).

The differential between ASD and psychosis is complicated by shared symptoms, especially in the social affective and cognitive domains (Couture et al., 2010) and genetic etiology (De Lacy & King, 2013). Further complicating differential diagnosis of ASD and psychosis, the ADOS-2 was not able to reliably distinguish ASD from psychosis in adults using the Western Psychological Services (WPS) or revised algorithms, with 30 to 50% of individuals with psychosis classified as ASD (de Bildt et al., 2016; Maddox et al., 2017). Differential assessment is best focused on the onset and trajectory of symptoms, necessitating a thorough developmental interview and record review, especially for adults not previously diagnosed with ASD. Autism symptoms are evident in the early childhood years in contrast to psychotic disorders, which generally emerge during later adolescence and adulthood. Additionally, individuals with non-ASD psychotic disorders have substantially lower rates of stereotyped and restricted and repetitive

behaviors. Evaluators are reminded that the incidence of psychosis in children is extremely rare, with ASD and pervasive developmental disorders preceding childhood schizophrenia onset 30 to 50% of the time (Rapoport et al., 2009).

Similar to many other psychiatric conditions, individuals with ASD show higher incidence of psychotic disorders, including schizophrenia spectrum disorders and bipolar disorders, than that observed in the typical population (Marin et al., 2018; Selten et al., 2015; Zheng et al., 2018). There are documented differences in the presentation of psychosis in individuals with ASD. Most notably, the duration of psychosis reported by individuals with ASD rarely meets full criteria for symptoms or duration of schizophrenic symptoms (minimum of 6 months disturbance with 1 month of active symptoms); this suggests an atypical more acute, transient psychotic course than that seen in the general population (Larson et al., 2017; Lugnegard et al., 2011). Further, it may be useful to investigate and interpret psychotic symptoms in individuals with ASD as related to the experience of prolonged social (e.g., bullying) or environmental stress (Keller et al., 2015).

### **Assessment considerations for Psychotic Disorders**

- Obtain self and collateral reports of psychotic symptoms, social behaviors, and ASD symptoms.
- Conduct a thorough interview of developmental history of symptoms.
- Obtain and review records from childhood.
- Pay careful attention to symptom onset and trajectory.
- Be aware of the higher co-occurrence of ASD and psychotic disorders in older teens and adults.

### **Visual & Auditory Sensory Impairments**

Rates of ASD are increased in individuals with sensory impairment. Evaluators conducting ASD evaluations for individuals with sensory impairment should be highly experienced ASD evaluators familiar with the range of presentation for both conditions.

#### *Blindness or Visual Impairment*

Vision should be assessed in all children referred for ASD evaluation. There are commonalities in symptoms observed in individuals with ASD and individuals with blindness/visual impairment (VI) who do not have ASD (Butchart, 2017). Individuals with blindness or VI have substantially increased incidence of ASD, with some studies suggesting up to one-third of totally blind children have substantial symptoms of ASD (Cass, 1998). However, ASD symptoms are often overlooked, as observed impairments are attributed to the sensory impairment (Jure, 2016). Further, the common ASD evaluation tools, including the ADOS-2, were not standardized on individuals with sensory impairments and may not be scored for individuals who are blind or VI (Lord, et al., 2012). Evaluators conducting evaluations for individuals who are blind/VI should be highly experienced with ASD evaluation and developmental presentations of VI (Jure, 2016).

### **Assessment considerations for Blindness or Visual Impairment**

- Obtain vision evaluation.
- Attend to social sharing, interest, and enjoyment.
- Attend to verbal social communication.
- Evaluators conducting ASD evaluations for individuals diagnosed blind or VI should be highly experienced ASD evaluators familiar with the range of presentation for both conditions.

#### *Deaf or Hard of Hearing*

Hearing issues can range from mild hearing loss to profound deafness that can be temporary (e.g., due to illness) or permanent (WHO, 1991). There are early childhood symptom similarities for those who are deaf

or hard of hearing and young children with ASD, including delayed babbling and language development, response to name, and poor or inconsistent social responsiveness that may result in referral for ASD evaluation. These symptoms are related to hearing and attending for children who are deaf or hard of hearing in contrast to the core deficits in social atypicality and interest for children with ASD. Moreover, there is a higher incidence of hearing impairment in individuals with ASD (Rosenhall et al., 1999), and there may be a higher incidence of ASD in children with profound hearing loss (Szymanski et al., 2012). Further, many caregivers report that they thought their child could not hear at an early age due to lack of response to name or social awareness. Based on the higher incidence of hearing loss and symptom similarities in early childhood, hearing evaluation is strongly recommended for children who have screened positive for ASD.

Similar to individuals who are blind/VI, assessment for individuals diagnosed deaf or hard of hearing is complicated by lack of standardized tools for this population (Szymanski et al., 2014). Specifically, the standardization sample of the ADOS-2 excluded children with sensory impairments and as such, the tool may not be scored for individuals who are deaf or hard of hearing (Lord, et al., 2012). This requires increased demands on evaluator clinical judgment and expertise, necessitating evaluators who are highly experienced with ASD evaluation and developmental presentations of deafness (Szymanski et al., 2014).

#### Assessment considerations for Deafness or Hard of Hearing

- Obtain hearing evaluation.
- Attend to visual social sharing, interest, and enjoyment.
- Attend to nonverbal communication, such as facial expression and gesture use.
- Evaluators conducting ASD evaluations for individuals diagnosed deaf or hard hearing should be familiar with the range of presentation for both conditions.

#### ***Special population considerations***

##### **Evaluation of very young children**

The goal is for early identification of ASD, and referrals are often made for children under 3 years old. Assessment before age 3 is achievable, though there are some important points to consider. Many young children with developmental delays present with some ASD features. Delayed young children without ASD generally have social

behaviors consistent with their developmental status or mental age; therefore, assessment of developmental skills is strongly recommended for very young children.

The presentation of ASD varies in early development. There are marked differences in ASD symptom presentation from infancy to age 2, age 2 to age 3, and 3 and beyond, when a more “typical” ASD presentation tends to be present (Volkmar et al., 2005). This requires evaluator awareness of and sensitivity to developmental changes in symptom presentation. Children under age 2 with ASD may not exhibit restricted and repetitive behaviors in multiple domains or at the level seen for older children (Lord, 1995). In contrast, the social and expressive language deficits may be more evident for very young children (Stone, et al., 1999). Scores on the ADOS-2 tend to be more stable than scores on the ADI-R for very young children (Kleinman, 2007). Younger children tend to show greater variability in their developmental scores at follow-up, suggesting that ongoing developmental/cognitive monitoring is essential (Klin et al., 2004). Additionally, there is less stability in ASD diagnosis before age 2, though children younger than 2 with ASD symptoms can clearly benefit from early intervention. Further, there is emerging evidence that ASD diagnosis at 14 to 16 months shows meaningful stability such that a child diagnosed by 14 months is likely to continue to present as ASD in formal evaluation at age three (Pierce et al., 2019). Stability of confirming or ruling out ASD, especially at young ages, is enhanced by the use of highly experienced clinicians (Klin et al., 2000; Stone et al., 1999).

Evaluators of children under the age of 3 should be highly experienced clinicians with expertise in both early childhood and ASD.

Evaluators seeing very young children with ASD should:

- Be highly trained in the pattern of developmental presentations of ASD at young ages and the need for clinical judgment when the child is not meeting full diagnostic criteria, especially lack of sufficient restricted and repetitive behaviors.
- Be aware that restricted and repetitive behaviors are not always present or as evident at this age (emerge later than the social and language deficits) and restricted and repetitive behaviors can be exhibited by typically developing toddlers.
- Consider family history of ASD as the rates of ASD are higher in a child with a sibling diagnosed with ASD.
- Use direct observation, including interactions with the parent and examiner.
- Complete developmental assessment at baseline and follow-up evaluations.
- Use standardized developmental and ASD tools and the DSM-5 criteria for ASD combined with clinical judgment to make clinical decisions and recommendations.
- Know that presentations prior to age 2 fluctuate with greater frequency, necessitating routine re-evaluation and intervention planning.

*Evaluators seeing very young children should not delay diagnosis and early intervention due to possible diagnostic uncertainty for a young child with prominent ASD symptoms. Early intervention with routine follow-up evaluation is recommended. Consider bringing the child back for evaluation in six months following treatment to update clinical status, progress, and response to intervention.*

### **First time evaluation of teens and adults**

Most individuals are referred for ASD evaluations in the early childhood or formal school-age periods. However, there are also times when a teen or adult present for an initial ASD evaluation. This may be due to mild symptoms only showing impairment in the adolescent or adult years, poor access to mental health care, or shared symptoms of ASD with other psychiatric differential and comorbid diagnoses. Notably, adults with ASD have a higher rate of psychiatric comorbidities, especially depression, than other clinically referred adults (Ghaziuddin & Zafar, 2008; Joshi et al., 2013). As such, the presence of other psychiatric conditions should not preclude the diagnosis of ASD in adults referred for ASD evaluation.

When completing initial diagnostic evaluations for older teens and adults, evaluators should:

- Obtain a strong developmental history of ASD symptoms from available caregivers.
- Obtain current symptom presentation, including adaptive deficits.
- Thoroughly review relevant past and current medical and school records.
- Conduct a thorough evaluation of differential and comorbid conditions.

### **Cultural issues in ASD evaluation**

*Cultural Diversity in Perceptions & Beliefs:* While ASD symptoms are similar across all cultures, the cultural background of the family influences help-seeking behavior, beliefs about diagnosis and disability, and acceptance of and preferred treatment interventions (Bernier et al., 2009). Evaluators must be culturally aware and sensitive to cultural issues, especially the stigma regarding ASD in certain cultures, when completing ASD evaluations. However, there is strong evidence that early identification (diagnosis) and



intervention with evidence-based treatments is the best means for any child with ASD to make gains and to improve their quality of life no matter the cultural group. Culture may impact the treatments sought with cultural beliefs that are more accepting of delays or that ASD will be outgrown, potentially leading to delays in seeking help (Tincani et al., 2009); cultural beliefs that the ASD can be “cured” may lead to seeking alternative therapies that state curing ASD as the goal (Ennis-Cole et al., 2013). African American families may be more likely to provide “protective care” that involves promoting independence skills and ensuring trustworthy supports, which has many benefits, but may also delay diagnosis and professional care for children with special needs (Burkett et al., 2015).

Evaluators should be knowledgeable of cultural and diversity issues and sensitive to families’ preferences and beliefs. Evaluators should use strong active listening skills when discussing these issues with families and should consider family needs and goals when making recommendations regarding the available evidence-based interventions for ASD.

#### *Linguistically Diverse & Limited English*

*Proficiency:* Providers must ensure that all eligible families have access to timely and quality evaluation and treatment, including families who speak a language other than English. Providers are required by Medicaid policy to provide professional interpretation services when needed

and requested by the family. Evaluators must be aware of the impact of language barriers on the evaluation process and data obtained from direct assessment for families and children of limited English proficiency or English as a Second Language (ESL) status. Ideally, direct assessment of skills should be completed in the child’s primary language by an evaluator competent in that language. However, having an evaluator who speaks the primary language of the family may not always be possible so an interpreter is utilized. When it is not feasible to conduct direct assessments in the primary language of the family, limitations of the standardized data obtained should be highlighted in the clinical report.

Whenever there are language differences in the evaluation process, the limitations in interpretation of standardized data and tool use must be strongly considered.

The ADOS-2 and ADI-R standardization samples did not include utilization of interpretation services or linguistically diverse populations (Harris et al., 2014), though the tools have been translated and validly used in many languages (Lord, 1994). Sometimes the child being assessed speaks English while the caregiver speaks another primary language. Caregivers who primarily speak a language different than their child may under-report communication deficits on the ADI-R (Vanegas et al., 2016). Additionally, there may be some variability in severity ratings on the ADI-R, such as for Hispanic children (Overton et al., 2007). For the caregiver interview, the translated version of the ADI-R should be utilized rather than having a professional interpreter translate the items for families with a non-English primary language.

The ADOS-2 should be used with caution with linguistically diverse populations, including individuals who are administered the ADOS-2 in their non-primary language. The ADOS-2 developers note that examinee comfort in the evaluation process is likely more important for the observational assessment than the language in which the tool was administered (see WPS Frequently Asked Questions (FAQ) website for more information on ADOS-2 use with linguistically diverse individuals; <https://www.wpspublish.com/app/OtherServices/FAQs.aspx#FAQ=0>). The ADOS-2 Toddler Module and Module 1 are largely based on nonverbal skills and, as such, there should be lower impact from language diversity, with Modules 3 and 4 likely showing the most impact. For individuals of ESL status whose parents have limited English proficiency, the tool can be used, but interpreted with caution depending on the individual’s comfort in the language utilized in the assessment. Given there is no available data to support scoring the ADOS-2 when an interpreter is utilized for the child being assessed, the measure should not be scored or interpreted with extreme caution when the interpreter was required for administration of the majority of the assessment.

Finally, evaluators should be aware that there is no data to support that bilingualism impacts language development for children with ASD or other developmental disabilities (Drysdale et al., 2014). As such, bilingual and non-English speaking families with bilingually exposed children (e.g., primary non-English language at home and English through school) should not be encouraged to adopt one language for their child. It is important for children in intervention services to continue to communicate with their family of origin, and English bias should not be present.

Assessment considerations for culturally and linguistically diverse families:

- Take into account the impact of cultural beliefs and perceptions in ASD symptom reporting and treatment preferences.
- Complete direct assessments in the child's primary language whenever possible.
- Focus on completing robust interview of symptoms and observational assessment, even if diagnostic tools cannot be formally scored.
- Note limitations of data obtained with linguistic barriers (e.g., ESL).
- Use available formal tool translations whenever possible rather than having interpreters translate clinical items.
- Be aware that caregivers who are language discordant with their child may under-report communication deficits.

Medicaid PIHP covers the cost of professional interpretation services.

### Caregivers who have limited historical or current knowledge

Given the ASD evaluation requires thorough evaluation of the developmental trajectory of symptoms beginning in early childhood, evaluations are complicated when the presenting caregiver has limited current or historical information on the child being assessed. This is often seen for children in foster care or who have had a change in their caregiving situation (e.g., recently adopted, with the other parent or family member). Although not having a solid developmental history can impact our certainty in the diagnostic process, evaluators should support medical necessity for care that is needed for the child based on the current symptom presentation. There should not be systematic bias against children in foster care or new caregiving situations.

Obtain as much collateral data (e.g., records, teacher reports) and observational information as possible when caregivers have limited current or historical information.

When the presenting caregiver has limited knowledge of the child, the following are recommended:

- Obtain as much symptom history information as possible through record review. Nearly all children have some pediatric medical record. Any child who has been in school will have some information on file, such as report cards, attendance, and state mandated standard educational assessments. Often children may have had contact with Early On or another early childhood intervention. For foster care situations, ensure the child's case worker attends the evaluation to provide any known information and to sign release forms allowing you to collect records.
- When allowed and consent provided, reach out to others who have information about the child. This may include teachers, day care workers, or family members.



- Conduct a thorough observational assessment *in addition to the ADOS-2*.
- Conduct developmental or cognitive assessment. This provides information on the child's mental age, which allows you to interpret your social observations.
- Be mindful of the shared variance in symptoms between ASD and traumatic stress for children with changes in primary caregivers.
- Draw preliminary or provisional diagnostic conclusions and treatment recommendations based on the data you obtained.
- Monitor the child's presentation and response to intervention.
- Reassess as needed and obtain as much information possible from intervention providers for re-evaluations.

### ***Considerations when individuals were previously diagnosed with ASD***

Evaluators will, on occasion, receive referrals for children who had a recent ASD evaluation completed by another evaluator. Children will also present who have had evaluations of specific skills, such as a recent school evaluation including speech or intellectual assessment. When feasible and deemed valid, data of these recent evaluations should be utilized. One notable exception: if the caregiver is specifically requesting a second opinion evaluation, the evaluation should be conducted as a full, initial evaluation.

In situations when the caregiver is requesting medical necessity for a specific service, a second opinion, but is seeking services, such as ABA, it is up to the evaluator to review the previous report to determine what evaluation components were completed and quality of the evaluation. It is cost and time effective to use data already obtained when possible to avoid redundancy. However, evaluators are reminded that completion of the medical necessity form is based on the evaluator's credential as a QLP and that the evaluator is certifying medical necessity (or lack thereof). Thus, the evaluator should minimally conduct an interview with the presenting caregiver regarding current needs and gather some observations of the child, even when data from previous evaluations is available.

If the caregiver is not specifically asking for a second opinion evaluation and the evaluation was completed within the last year, use reliable components from the recent ASD evaluation to support medical necessity, including the necessary components:

- ADOS-2 score and descriptive observations.
- Caregiver interview with information needed for proof of medical necessity criteria (DSM-5 symptoms) and enough information to make a clinical determination on the need for ABA.
- Information on developmental, emotional-behavioral, and adaptive functioning to complete the DD-CGAS.

Any necessary components not previously completed or not completed to the extent necessary to justify the clinical conclusions and recommendations in the previous evaluation should be conducted by the evaluator. Further, any additional components the evaluator deems necessary to support the diagnosis, treatment recommendations, and medical necessity should be completed.



## Chapter 4.

### Evaluation Results, Feedback, Recommendations for Management & Behavioral Health Service Eligibility

After completing initial comprehensive ASD evaluations and annual re-evaluations, the primary evaluator (and other members of the evaluation team when applicable) is responsible for drawing conclusions based on the data determining if a child meets criteria for a diagnosis of ASD and meets medical necessity criteria for ABA services. Caregivers are then presented with the results through a face-to-face feedback session, with the option of including the supports coordinator, assigned clinician, other professionals (e.g., parent support partner), and/or friends or family in the session. In addition, the evaluation results, conclusions, and recommendations are communicated to the family, supports coordinator and other providers through a written evaluation report. The results of the evaluation and determination of medical necessity are also communicated to MDHHS through the completion of the waiver support application (WSA) form (see Chapter 5). Evaluators and supervisors may find the ASD Evaluation Quality Checklist helpful for ensuring that best practice in ASD evaluation has been followed (see Appendix J).

#### *Feedback on Comprehensive ASD Evaluations*

Providing feedback to the child's family is an essential role of the evaluator. Per the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (2017), psychologists are required to "take reasonable steps to ensure that explanations of results" are provided to the individual or individual's designated representative, such as the child's parent or guardian (9.10 Explaining Assessment Results). Caregivers seek a comprehensive ASD evaluation to answer questions about the child's functioning, address concerns about developmental delays, and identify the appropriate services and supports for their child. The evaluator needs to clearly communicate results and recommendations to the child's caregivers. Face-to-face feedback sessions are strongly recommended by MDHHS and are considered best practice for ASD evaluations (Saulnier & Ventola, 2012; Nissenbaum et al., 2002). Providing feedback by phone, via a letter, or notice of adverse benefit determination are not sufficient to address the clinical needs of the child and to adequately communicate the results to the child's caregivers. Caregivers may lack the ability to ask questions and determine collaboratively the next steps to best help the child. These methods should only be used when necessary due to special circumstances, such as when the child's caregivers are not able to be reached by phone or letter to schedule the feedback conference, the family has missed previous feedback session appointments, or the family cannot attend due to extreme personal barriers (e.g., chronic medical condition, transportation).

#### **Scheduling of the Feedback Session**

Many families have experienced delays in obtaining the initial evaluation and accessing services, such as having concerns dismissed by the child's medical providers (Ahern, 2000; Goin-Kochel et al., 2006) and waiting to schedule the evaluation. Further, caregivers are generally

more satisfied with the ASD evaluation process when there is less time waiting for a diagnosis and there are fewer professionals who have been involved in the process (Goin-Kochel et al., 2006). Evaluators are strongly recommended to schedule the face-to-face feedback session as quickly as possible following the initial diagnostic evaluation. It is often helpful to schedule this session immediately following the evaluation appointment and to provide families with reminders, such as letters, phone calls, or other electronic messages (text, email, through a client portal, etc.). Caregivers should be informed of the purpose of the session (to discuss the child's functioning and diagnosis; discuss recommendations for treatment). It is

Face-to-face feedback sessions with the caregiver are *strongly* recommended for all initial comprehensive diagnostic evaluations and annual re-evaluations.

important evaluators connect with the family throughout the evaluation process and show compassion. This rapport will also help the family feel supported at the feedback session. When scheduling the feedback session, caregivers should be encouraged to bring other family members or friends for support. Depending on the family's preferences, the supports coordinator, referral source (e.g., clinician), and/or other professionals should be included in the feedback session. Ideally, other professionals will also participate face-to-face to provide the maximum support to the family. If this is not possible, other methods (e.g., phone, Health Insurance Portability and Accountability Act compliant online video conferencing) can be used to include others in the feedback conference (with signed permission from the family).

It is preferable to complete feedback sessions with adult caregivers only. Having the child who was assessed present during the session can be disruptive to the discussion of the results, as the caregiver may be distracted by managing the child's behavior. In addition, it may be confusing and upsetting for children to hear about a diagnosis and test results during the feedback conference. With older children and adolescents, direct presentation of the feedback may be beneficial. Evaluators should work collaboratively with the child/adolescent and the family throughout the evaluation process to determine how best to structure the feedback session. In some cases, it may be helpful to meet with the caregivers first to provide thorough feedback results and to then determine what the parent/guardian's preferences are in telling the child of his or her diagnosis. If a family would like the child to be included in the session and/or if a child/adolescent requests to participate, evaluators will need to develop a plan with the family about how to set up the session and how to communicate the results in an effective manner.

Feedback sessions should be scheduled for a *minimum* of 45 to 60 minutes to allow for a thorough discussion of the results, review of the recommendations, and the opportunity to answer any questions the caregiver and others in attendance may have. Evaluators should not appear rushed or talk too quickly, as receiving the results of a diagnostic ASD evaluation is often an emotional and taxing experience for caregivers. Evaluators should strive to schedule feedback sessions at a time that is convenient for caregivers and allows them to invite whomever they would like to the appointment. The setting of the feedback session should be quiet, free of distractions, and as private as possible. Having comfortable chairs and a set-up of furniture that encourages collaboration and communication can also help facilitate the session (Nissenbaum et al., 2002; Shea, 1993).

## **Completing the Feedback Session**

Evaluators should present feedback on the results, diagnostic impressions, and recommendations to caregivers in a warm and empathic manner. Evaluators need to be knowledgeable about ASD and associated difficulties as well as differential diagnoses when the evaluation results do not support an ASD diagnosis. Evaluators also should be familiar with the range of services in their region, including ABA services and other services and supports.

It will often be helpful to structure the feedback session by first reviewing the reason for referral and the caregiver's concerns. Throughout the evaluation process, examiners should determine what the caregiver's expectations are in completing the evaluation and how ready the caregiver is to receive a particular diagnosis (Osbourne & Reed, 2008). Some families may not be expecting an ASD diagnosis, even though they sought the evaluation. In contrast, other families may express a sense of relief when being informed of the diagnosis because their concerns have been validated and may welcome the feedback (Nissenbaum et al., 2002). Table 5.1 summarizes recommendations for completing feedback sessions. Evaluators are encouraged to review the resource, "A clinician's guide to providing effective feedback to families affected by autism" (Austin, Katz, & Reyes), which is available through Autism Speaks (<https://www.autismspeaks.org/tool-kit/atnair-p-guide-providing-feedback-families-affected-autism>). There are also videos available on the website to accompany this manual and a quality checklist for feedback sessions; these resources may be particularly helpful for trainees and less experienced evaluators.

Figure 5.1. Recommendations for Conducting Feedback Sessions With Caregivers

<p><b>General Strategies for Feedback:</b></p> <ul style="list-style-type: none"><li>● Be well-organized and prepared prior to the session, including familiarizing yourself with the test results, specific observations of the child, and recommendations, and having any needed forms (e.g., release of information, consent to exchange) available to complete with the family.</li><li>● Use good communication skills, including reflective listening and nonverbal communication strategies.</li><li>● Speak slowly and clearly, with frequent pauses to allow for questions and reflections from caregivers.</li><li>● Develop a small list (3-4) of key points to review prior to the session; summarize key points (take-home messages) at the end of the session.</li><li>● Express high levels of warmth and empathy.</li><li>● Monitor your own emotional reactions, even when faced with intense emotions from parents.</li><li>● Allow time for questions.</li><li>● Include other family members and sources of support for the family.</li><li>● Use an interpreter when needed with families from non-English speaking backgrounds.</li></ul>
<p><b>Strategies for Feedback When Child is Diagnosed with ASD:</b></p> <ul style="list-style-type: none"><li>● Be knowledgeable about the ASD diagnosis and treatment options, including ABA services.</li><li>● Discuss next steps for obtaining services and needed supports.</li><li>● Support the family's preferences for treatment and other services.</li><li>● Offer hope to the family while also being open, honest, and realistic about the ASD diagnosis and the child's functioning level.</li><li>● Be prepared for a range of parental reactions and strong emotions.</li><li>● Emphasize child and family strengths.</li></ul>
<p><b>Strategies for Feedback When Child is <u>Not</u> Diagnosed with ASD:</b></p> <ul style="list-style-type: none"><li>● Explain the process of the evaluation and why the child does not meet criteria for ASD based on an integration of the data (i.e., not just ADOS-2 score).</li><li>● Provide the family with a clear case formulation, including a diagnosis when appropriate (there usually is a reason the child was referred for the evaluation).</li><li>● Discuss recommendations for other needed services and referrals.</li><li>● Inform family of the right to seek a second opinion on the diagnosis.</li></ul>

### Sharing Diagnostic Information and Recommendations

During the feedback session with families, evaluators should discuss the importance of sharing the evaluation results and coordination of care with other professionals involved in the child's treatment. In particular, evaluators are encouraged to communicate findings and coordinate care with the child's primary care provider and any other referral sources (e.g., clinician, supports coordinator). It is also important to emphasize to families that sharing the report conclusions and recommendations will assist with collaboration among different service agencies and providers to best help their child.

Evaluators should explain to caregivers the process of obtaining a copy of the final clinical report for their own records. This process varies among different organizations so evaluators will need to be familiar with their own agency procedures. The evaluator should also discuss with families the process for completing a signed release when needed to send the written report and/or give verbal feedback to external providers. It is important that the consent to exchange and release information be clearly explained to caregivers so they understand their rights in sharing (or choosing not to share) the report and diagnostic information with others. When providing verbal or written results and information to other providers, evaluators should take care to provide the minimum needed information and to protect the privacy of the family and child privacy as much as is possible.

Evaluators are responsible for completing the *Consent to Share Behavioral Health Information* (form MDHHS-5515) when sharing information between different providers. Per the Michigan Medicaid Manual (1.8.A., STANDARD CONSENT FORM), this form is required by MDHHS to allow for health care providers to share behavioral health and substance use disorder information. The consent is required to be accepted, honored, and used for all Fee for Service (FFS), Managed Care and Prepaid Inpatient Health Plan (PIHP) beneficiaries both from and to any of those providers or entities. This form was developed to ease communication among providers and different organizations, as well as to be compliant with state and federal privacy laws.

### ***Clinical Report***

The purpose of the clinical report is to communicate the results of the data collected in the comprehensive diagnostic evaluation, summarize the conclusions of the evaluation, and provide recommendations to the family. The report often serves to grant the individual access to needed services, including ABA services, other services authorized through the child's treatment plan within the individual plan of service (IPOS), and school special education. Another function of evaluation reports is to serve as evidence of the service provided, and as such, it is often necessary to describe the evaluation procedures, tests administered, and the results of assessment measures. However, this does not mean reports need to be technical and emotionless, simply a list of scores and checkboxes next to behaviors and symptoms (Schneider et al., 2018). Well-written evaluation reports provide a summary of the information gathered that is understandable to the family and others reading the report, include observations and details that are *specific* to the child and family, and clearly support the diagnosis and recommendations.

The use of templates is a common practice among evaluators and often an excellent strategy to improve efficiency. However, reports that overly rely on boilerplate language may be deemed as insufficient to support the conclusions in the report. Further, long sections of clearly templated language will likely be skimmed by the reader, thus failing to communicate the results effectively (Schneider et al., 2018). It is also essential evaluators consider how the report may be received and interpreted by the family. Errors in the child's name, basic demographic characteristics, details about the assessment process, and unclear conclusions will not be helpful to the family and are not tolerated in the Medicaid system. In addition, errors in details about the child and family will undermine the conclusions in the report and the family's confidence in the evaluator and the assessment process. This leads to overall dissatisfaction with the evaluation process and may drive families to seek a second opinion on the diagnosis and determination of medical necessity for ABA services.

When using a report template, make sure to include details that are *specific* to the child. At minimum, include:

- Review of background information obtained (e.g., developmental and medical history, academic history, history of intervention provided, family history).
- Caregiver report of the child's ASD symptoms and emotional/behavioral functioning.
- Behavioral observations.
- Summary of the child's behavior during the ADOS-2.
- A formulation that includes:
  - clear reasons for the determination (or rule out) of the ASD diagnosis,
  - discussion of differential or comorbid diagnoses, and
  - a description of child's strengths.
- Clear and necessary recommendations based on evaluation results.



Reports should be well-organized, with the organization of the report serving to support the conclusions and recommendations. There are many variations of style and formatting that are acceptable for reports; many agencies also have a preferred style and organization. Evaluators should use consistent formatting throughout the report, including font and spacing. It is also important to follow style and grammar guidelines consistently and to reduce typos and grammatical errors as much as is possible to improve the readability of the report. There are no specific requirements for report length per MDHHS guidelines. In general, reports should be long enough to answer the referral question and to communicate the data clearly. Evaluators should be mindful that overly detailed and lengthy reports may reduce the usefulness of the report. Avoid irrelevant information, recommendations that are not needed for the child, or excessive “filler” from templates that is not specific to the child. Evaluators should strive to be precise in their wording choices and to organize information in a clear and concise manner as much as is possible. Figure 4.2 summarizes general guidelines for evaluation reports.

Figure 4.2. Report Writing Guidelines For Evaluation Reports.

<p><i>Do:</i></p> <ul style="list-style-type: none"><li>• Write clearly and as concisely as possible.</li><li>• Proofread carefully.</li><li>• Clearly state the reason for referral and make sure to address referral question(s) in the formulation and conclusions.</li><li>• Use person-first language (e.g., “child diagnosed with Autism Spectrum Disorder” rather than “autistic child”).</li><li>• Make the report specific to the child.</li><li>• Make recommendations that are tailored to the child’s needs .</li><li>• Include targets for intervention.</li><li>• Describe strengths of the child and family.</li><li>• Be sensitive to the family’s cultural background, preferences, and needs.</li></ul> <p><i>Avoid:</i></p> <ul style="list-style-type: none"><li>• Overreliance on template/boilerplate language.</li><li>• Using the wrong child’s name (upsetting to families and a HIPAA violation).</li><li>• Including other incorrect details (wrong pronouns, incorrect description of child’s appearance or behavior, referring to mother when child lives with grandparents, etc.).</li><li>• Including recommendations that are not applicable to the child or family (e.g., including recommendation for ABA for a child who is not diagnosed with ASD).</li><li>• Use of checkboxes of symptoms or ADOS-2 items (long and confusing to read; are not specific to child; limited integration of data).</li><li>• Extensive use of jargon, technical terminology, or abbreviations that may not be easily understood by caregivers or professionals from other disciplines.</li></ul>
---

## Report Components

The following is an overview of the various sections included in the clinical report. The heading labels and organization of sections will vary depending on the template used and evaluator preference. Regardless of the exact order and style, the report should be comprehensive, include integration of the data collected, and ultimately, help the child and family. Appendix K includes several sample report templates that can be adapted to help evaluators organize the evaluation data and communicate the results clearly.

### *Reason for Referral*

The reason for referral should include brief information about why the child’s caregivers sought the evaluation. This should be tailored to each child and include specific concerns from the caregivers. Further,



concerns from other referral sources (e.g., child's pediatrician, school personnel, assigned clinician) should be described. The reason for referral should serve as a context for the remainder of the report, with the goal of answering the questions raised in the referral in a clear and understandable manner. It is often helpful to summarize the referral question(s) again in the summary/case formulation section in order to organize the findings and to make the report as helpful as possible.

### ***Background/History***

In this section, evaluators summarize details about the child collected from a variety of sources, including the caregiver interview, medical records, concerns from referral sources, previous psychological, speech and language, or occupational therapy evaluations, and information from schools (e.g., IEPs, teacher observations, prior assessments, etc.). The most challenging aspect of writing the background section is to summarize the relevant information in a succinct manner. Less experienced evaluators tend to have more difficulty deciding what to include and how to organize information. Use of section headings (family information, medical history, developmental history, school information, etc.) can be a helpful way to organize information, both easing the writing process and making the report clear and easy to follow. Chief clinical officers and supervisors should provide feedback to evaluators to assist in improving their clinical skills and report writing. See Appendix K for examples of how to organize the history section in the clinical report.

### ***Review of ASD symptoms/ADI-R***

Information about ASD symptoms, including an individual's verbal and nonverbal communication, social interaction skills, and restricted, repetitive, and sensory-related interests and behaviors is obtained through an interview with the child's caregiver (ADI-R or equivalent interview). Details about possible ASD symptoms can be included in the background section or in a specific section summarizing ASD symptoms/ADI-R results. Evaluators should include specific details about the child's functioning, including both strengths and weaknesses in communication and social skills. Examples of the child's behavior in different settings (e.g., home, playground, school, child care center, etc.) is also helpful to explain behaviors in context. This is often especially important when summarizing interview information when a diagnosis of ASD is not supported by the overall data.

It is often confusing to parents and other professionals to review a lengthy list of ASD symptoms based on the caregiver's report, only then to have the evaluator conclude later that the child does not have ASD. Providing specific examples and drawing contrast of the child's behavior between different contexts will help support the conclusions and more accurately describe the child. Further, using a template with an extensive list of possible ASD symptoms that are checked off by evaluators is not recommended; this seems impersonal and does not result in a report that is specific to a child.

### ***Behavioral Observations***

As outlined in Chapter 3, best practice diagnostic evaluations include observations of the child in both a semi-structured observational assessment and during other portions of the evaluation (i.e., developmental or cognitive testing). Behavioral observations serve to put the standardized test results in context and highlight personal details of the child. These sections often include description of the child's social presentation (including ease of establishing rapport), level of communication, attention, motivation and effort, behavioral control, response to feedback, and any unusual behaviors or reactions. Evaluators should ensure that the observations are relevant to the child's

When using the ADI-R, be cautious in interpreting the algorithm recommendations as ruling in or ruling out an ASD diagnosis. Caregivers may over- or under-report symptoms for a variety of reasons. Further, evaluators should never rely on only one piece of information to make a diagnosis.

developmental level, clinical presentation, and the referral question. Further, it is often useful to summarize how difficulties in instructional control, attention, and communication may have affected the overall results.

### ***Cognitive/Developmental Testing***

As emphasized in Chapter 3, assessment of an individual's developmental, cognitive, and language levels is needed to code and interpret data from the ADOS-2 and ADI-R and to appropriately consider potential differential diagnoses. Evaluators should include a review of the overall test findings, explain test scores (such as standardized scores and percentiles), and provide clear interpretation of the data. Highlighting strengths and weaknesses as well as potential areas for intervention, is useful when summarizing developmental/cognitive test results.

Young children are often difficult to assess due to developmental delays, separation anxiety, inattention and hyperactivity, and weak expressive and receptive language. When working with young children, emphasize that test results should be interpreted cautiously and only reflect a child's current functioning level.

### ***Adaptive Behavior Assessment***

Adaptive behavior assessment (e.g., Vineland-3, ABAS-3) is also a key component in understanding a child's current functioning level and identifying targets for intervention. Evaluators are encouraged to summarize test scores and findings of adaptive behavior assessment, including describing relevant strengths and weaknesses. Given issues with accurate reporting from caregivers, as well as the impact of possible differential and/or comorbid diagnoses, evaluators need to provide interpretation of the findings and note possible explanations of the adaptive behavior skills reported by the caregiver.

Per the MDHHS Medicaid Provider Manual, evaluators are required to determine the DD-CGAS (Wagner et al., 2007) in all initial diagnostic evaluations and annual re-evaluations. It is important to note that information summarized in the overall DD-CGAS score should be obtained from a variety of sources, including standardized test data, informal observations, caregiver report (including clinical interview and completion of an adaptive behavior measure), and other collateral data when available (e.g., school records). The DD-CGAS is not considered or intended to be a test in itself; rather, it is a tool for describing the child's overall functioning and to aid in tracking outcomes of interventions.

### ***Observational Assessment of ASD Symptoms/ADOS-2***

Administration of the ADOS-2 and interpretation of the child's behavior is a required component of initial ASD diagnostic evaluations and annual re-evaluations. The ADOS-2 often serves as primary evidence for supporting or ruling out an ASD diagnosis. However, the ADOS-2, as with all assessment instruments, should never be used in isolation to determine a diagnosis. Given that many factors can affect a child's social and behavioral presentation during the ADOS-2 (e.g., extreme shyness, oppositional behavior, etc.), the written summary of the ADOS-2 needs to provide a thorough description of the child's behavior, including explaining possible indicators of ASD symptoms in the context of the assessment, rather than simply a list of the algorithm items. Evaluators should include specific examples of the child's behavior, provide interpretation of behaviors and possible symptoms, and emphasize both strengths and weaknesses of the child. If the ADOS-2 score and descriptive category based on the algorithm cutoff are not consistent with other data points, evaluators should provide an explanation of the data and describe how other factors may have influenced the child's presentation. Overall, the ADOS-2 summary should serve as a review of the child's behavioral presentation and the symptoms displayed during the observational assessment.

MDHHS requires inclusion of the total ADOS-2 score (with the appropriate module clearly stated) in evaluation reports. However, including a complete list of scoring of individual algorithm items is *not* required or recommended. The summary of the ADOS-2 should describe how the child performed during various activities and clearly indicate whether ASD symptoms were or were not present; this summary should be sufficient for other professionals to understand the scoring of individual items.

### ***Summary/Case Formulation***

The summary provides an overview of the results, integration of the data, and conclusions about the individual's diagnosis and current clinical presentation. If reports are well-organized, the conclusions and diagnostic impressions should flow easily and be clearly supported by the data presented in earlier sections. Summary and recommendations sections may be the only parts of reports that are read by others. As such, it is essential to write clear, specific conclusions, diagnosis or diagnoses, and recommendations that are supported by the data. Summaries should be as succinct as possible while also including the necessary information to support the diagnosis and conclusions. Only include diagnoses that are a) within the evaluator's scope of practice to diagnose and b) are included in the ICD-10 and DSM-5. Figure 4.3 summarizes guidelines and strategies for writing a clear case formulation and summary.

Figure 4.3. Strategies for Writing Clinical Summaries and Diagnostic Impressions.

- Structure the summary section by briefly describing and integrating information from the referral question, child's background and history, interview data, behavioral observations, and test data and interpretations.
- Briefly describe and reference specific test results and background information rather than repeating the exact wording from previous sections.
- All information in the summary should be from previous sections in the report; do not introduce new information or data.
- Clearly explain why a diagnosis is being made based on integration of data; do not state a diagnosis is made based on only one piece of information (e.g., ADOS-2 score).
- Write as concisely as possible.
- Be direct and clear when stating a diagnosis or diagnoses.
- Describe the individual's strengths and weaknesses.

Be mindful about including *rule-out* diagnoses. It is not possible to assess for every potential symptom or understand every aspect of a child's presentation based on a single evaluation. In addition, some diagnoses need to be considered in the context of a child's developmental level and may need to be deferred pending intervention and maturation. Including a long list of all possible rule-out diagnoses that were not assessed for (e.g., ADHD, intellectual disability, language disorder, oppositional defiant disorder, specific learning disorder, etc.) is not helpful to the child or family. All rule-out or provisional diagnoses should have a clear justification for their inclusion. Further, the evaluator should include specific recommendations for further evaluation and monitoring that is needed to assess for possible rule-out diagnoses.

## Recommendations

The ultimate goal of initial comprehensive diagnostic and annual re-evaluations is to determine the appropriate services for a child, including enrolling in ABA when deemed medically necessary. Recommendations should present an overview of high-priority services, supports, treatment targets, and accommodations for the child. The recommendations should be consistent with the child's history and current presentation, integration of test results, and diagnostic impressions included earlier in the report. The number and scope of recommendations should be realistic and manageable for the family. It is also helpful to keep recommendations time-limited, focusing on interventions and services that can be implemented within the next year, rather than throughout a child's development (Saulnier & Ventola, 2012). It is essential recommendations are tailored to the child and family. This means that evaluators should strive to include personal details and clear justifications for specific recommendations whenever possible, even when working from a report template (Schneider et al., 2018).

Recommendations sections should be well-organized, including organization by specific domains (e.g., medical, educational, family resources, etc.). Evaluators should work within their level of expertise when making recommendations for professionals in other disciplines. For example, it is appropriate to recommend additional medical evaluation, such as referral to a neurologist, genetic specialist, psychiatrist, or other medical providers. However, evaluators without the necessary medical training should not make recommendations for specific medications, other medical treatments, or tests or procedures. Figure 4.4 summarizes key points in writing recommendations for the child and family.

Figure 4.4. Key Points for Recommendations.

- Make recommendations *specific* to child, including child's age, developmental level, diagnosis, and family needs.
- Include justification for recommended services, supports, and accommodations.
- Consider all available services within your PIHP and region, including ABA, outpatient therapy services, family support, educational services, auxiliary services such as speech and occupational therapy, and other services (e.g., community living services, respite).
- Think of recommendations as a "to do" list for families:
  - Keep the number of recommendations manageable and realistic.
  - All recommendations should be *necessary* for child and family.
  - Recommendations should focus primarily on services and strategies that can be implemented within the next year.
- Organize recommendations by domain (e.g., treatment/clinical services, medical, educational, family, additional resources, etc.).
- Put high-priority recommendations near the top of the list.
- Include referrals for outside providers and other evaluations when needed.
- Be specific about timelines for re-evaluation and recommended monitoring.

## Summary of Report Writing and Organization

The clinical report serves as documentation of the ASD evaluation process and the need for services and supports for the child. Reports remain part of the child's medical record and are often shared with many professionals from different disciplines, including ABA providers, supports coordinators, health professionals, and school personnel. Evaluators are responsible for communicating results clearly and supporting the diagnostic impressions and recommendations made based on the data collected in the evaluation. Supervisors and administrators need to provide appropriate support to evaluators to allow for appropriate management of data and writing time to formulate reports that are specific, clear, and helpful to the child and family.

The following are key points about evaluation reports:

- Reports should be well-organized, carefully edited, and as clear and concise.
- Reports should include specific information about the child's background, behavioral presentation, and social behavior observed during the ADOS-2 and other portions of the assessment.
- The case formulation and diagnosis should be supported by integration of clinical data; a single data point should *never* be used in isolation to rule in or rule out a diagnosis.
- Recommendations should be specific to the needs of the child and family, address the range of services the child may need, and be realistic for the family.

With caregiver consent, evaluation reports should be sent to the primary care provider/pediatrician, treatment providers, and supports coordinator. Obtain consents for sharing the report for coordination of care.

### ***Recommendations, Referrals, and Treatment Considerations***

As emphasized throughout this manual, the diagnostic evaluation process is more than simply determining eligibility for ABA, as the primary goal is to help the child and family. Yet, determining medical necessity for ABA is an essential role of the evaluator (see Chapter 5). The evaluator is also responsible for making recommendations for other appropriate services and supports for the child and family, including referrals to medical providers and specialists, family and community supports. Further, the examiner is responsible for making necessary and appropriate recommendations and referrals for individuals who do *not* qualify for a diagnosis of Autism Spectrum Disorder or for whom ABA is not determined to be medically necessary. The following section summarizes various domains and interventions to be considered in recommendations for individuals who are diagnosed with Autism Spectrum Disorder. Evaluators may find the handouts developed by the Michigan Autism Council helpful, including the Provider Guide for Referral for Young Children with ASD (see Appendix L) and After Identification of ASD Guide for Parents (Appendix M).

### **Applied Behavior Analysis (ABA)**

Per the MDHHS Medicaid Provider Manual, evaluators determine the child's diagnosis, recommend general ASD treatment interventions, and refer the child for a behavior assessment provided or supervised by a BCBA to recommend more specific ASD treatment interventions. Treatment targets and interventions are determined collaboratively with the family, BCBA, and supports coordinator. Evaluators (through the initial diagnostic evaluation and annual re-evaluation) also should provide input regarding the individual's overall functioning and recommended targets for intervention. The BCBA should coordinate with other service providers, such as the child's psychiatrist, neurologist, primary care physician, school multidisciplinary team, as needed. At minimum, BCBAs should share bi-annual reports when assessments/re-assessments are completed with services providers. BCBAs also should document and share findings as needed when new goals are developed or when significant progress has been made by the child.

ABA can vary in the following domains:

- Location: Home or center-based.
- Intensity (number of hours per week).
  - 1 to 15 hours of ABA treatment per week is considered *Focused Behavioral Intervention*.
  - 16 to 50 hours of ABA treatment per week is considered *Comprehensive Behavioral Intervention*.
- Treatment targets and interventions.



Treatment targets for children, adolescents, and young adults diagnosed with ASD may include one or more of the following domains:

- Communication
  - Improving nonverbal communication skills, such as eye contact and pointing.
  - Expanding child's use of words for requesting, labeling, answering questions, and/or participating in conversations.
  - Use of nonverbal communication systems.
  - Improve child's understanding of instructions, prompts, and questions.
- Social interaction skills
  - Improving child's ability to attend to others and surroundings.
  - Learn how to engage in reciprocal play with peers and adults.
  - Practice social initiations and greetings.
  - Learn how to maintain interactions.
  - Improve child's interest in others' preferences and interests.
  - Practice sharing and taking turns in play and conversations.
  - Learn developmentally appropriate play and social interaction skills.
  - Improve interpersonal boundaries; reduce physical overtures such as grabbing, pulling, or using another person's hand as a tool.
- Reduce challenging behaviors
  - Extreme outbursts/meltdowns.
  - Aggression toward others (biting, kicking, hitting).
  - Self-injurious behaviors (head-banging, eating of non-edible objects, biting/scratching self).  
Elopement (particularly in public).
  - Verbal aggression/threats.
- Improve adaptive behavior skills
  - Implement a toilet training program.
  - Expand child's food repertoire and eating habits (often in conjunction with multidisciplinary feeding clinic or individual providers such as occupational therapist, primary care provider, nutritionist, GI specialist, etc.).
  - Improve child's safety awareness (e.g., ability to understand simple instructions, recognize stop signs or other symbols, etc.).
  - Improve child's ability to brush teeth, dress self, or complete other self-care tasks.

### Other Evidence-Based Therapy Services for ASD

When determining whether a child meets medical necessity criteria for ABA services, evaluators will need to consider whether intensive ABA is the appropriate level of care to address current symptoms and deficits. If ABA services are not deemed medically necessary given the individual's current presentation or if the family is not currently interested in these services, other clinical services, such as individual or family therapy, social skills groups, and/or parent management training, may be warranted. These services may also be appropriate when individuals are stepping down from intensive ABA to outpatient therapy. Evaluators should include specific recommendations for other clinical services when needed and discuss the range of options in the feedback session. Particular consideration should be given to necessary therapeutic interventions considering the child's functioning level and any comorbid diagnoses. Therapy services may be home- or clinic-based (outpatient) and may range from 1 to 2 sessions a month to several times a week, depending on the child's diagnosis and level of impairment.

Clinical services may include but are not limited to:

- **Behavioral therapy**, including principles from Applied Behavioral Analysis, conducted in the outpatient setting. Consultation with a BCBA/BCaBA/QBHP, psychologist, or other qualified professional within the community mental health setting may also be needed to conduct a **functional behavior analysis**

(FBA) to develop a positive behavior support plan that can be implemented in home or community settings.

- **Parent management training** is also often needed for children with ASD to address behavioral issues at home, particularly when children are also diagnosed with ADHD, oppositional defiant disorder, or conduct disorder.
- **Social skills interventions** are also often beneficial and can be conducted in individual or group settings. These interventions focus on targeted skill-building of social interaction skills, such as developing peer relationships, improving conversational skills, and building cooperative play skills.
- Skill-building on **emotional regulation** is also often helpful to children and youth with ASD to improve positive coping skills and understanding of one's emotional states.
- Particularly for older children and teens with mild ASD, individual or family therapy that includes approaches from **cognitive-behavioral therapy (CBT)** and/or **acceptance and commitment therapy (ACT)** may be helpful to build positive coping skills, address comorbid anxiety or mood symptoms, and/or target trauma-related symptoms.

## Medical Services and Referrals

Individuals diagnosed with ASD often are medically complex and require medical care coordinated with behavioral therapy and other services. It is essential that evaluators include appropriate recommendations and referrals for needed medical assessment and treatment in clinical reports and discuss these referrals with caregivers during the feedback session. Evaluators need to be knowledgeable about medical conditions that commonly co-occur with ASD, such as seizures, sleep difficulties, feeding problems, and gastrointestinal conditions (Bauman, 2010). Further, evaluators need to be familiar with the types of specialists to refer children to for various medical evaluations and treatments.

The following include possible medical recommendations for individuals diagnosed with ASD:

- **General pediatric care and monitoring:** All children and youth diagnosed with ASD should continue routine pediatric monitoring, including well child visits, screenings, and following the recommended vaccination schedule (see Appendix H for details about recommended vaccinations by age group). The child's primary care physician/pediatrician also can determine whether referrals to other specialists or additional laboratory tests/procedures are needed for the child.
- **Other Medical Specialists:** Referrals to other specialists may be warranted based on a child's medical history, current symptoms, and/or to rule out possible medical explanations for the child's ASD diagnosis and associated developmental delays. These specialists may include:
  - Neurology
  - Genetics
  - Gastroenterology
  - Allergy/immunology
- **Psychotropic medication:** Although there are no medications that target ASD symptoms specifically, medications may be helpful in targeting symptoms associated with comorbid conditions (e.g., ADHD, anxiety) and in management of irritability and agitation associated with ASD. Evaluators should recommend a referral for psychiatric evaluation when needed to clarify the child's diagnosis and determine the need for pharmacological intervention. Evaluators should also be knowledgeable about the current evidence-based practices regarding the use of psychotropic medication in children and youth in order to guide families and to make well-informed recommendations (see, for example, the review by Ji & Findling, 2015).
- **Management of sleep problems:** Sleep difficulties, including problems falling asleep, frequent awakenings at night, bedwetting (enuresis), and snoring, commonly occur in individuals with ASD. Medical evaluation, such as consultation with the child's pediatrician or a neurological evaluation, is often helpful to better understand possible medical causes to sleep difficulties. A referral to a behavioral sleep specialist may also be helpful.



- **Hearing and vision screening:** Particularly when working with young children with ASD, evaluators should ensure that children have had recent screenings of their hearing and vision. Hearing and vision difficulties may be harder to identify in young children with ASD given these individuals may be nonverbal and have other developmental delays. Further, hearing issues may be contributing to speech and language delays and social interaction difficulties.

### Ancillary Services and Supports

Evaluators should be familiar with the full range of services and supports available through their PIHP/ CMHSP and recommend appropriate services to meet the child's needs. Eligibility for these services varies based on the child's functioning level and family needs. As such, the assigned supports coordinator should work closely with the evaluation team, assigned BCBA, and family to determine the necessary supports and services for the child and assist with authorizing needed services in the IPOS. Further, when children are in foster care, it will be important for evaluators to consider the range of services available within MDHHS and coordinate with the child's foster care caseworker when making recommendations for services.

Given that language delays and communication deficits are commonly associated with ASD, evaluators are encouraged to recommend **speech and language therapy** to address difficulties in receptive language, verbal expression, pragmatic language skills (e.g., conversational skills), and/or articulation. **Occupational therapy** is also often recommended for individuals with ASD to build functional fine motor skills, such as grasping and manipulating small items, expanding adaptive behavior skills (e.g., dressing self, eating with utensils, etc.), and addressing sensory integration issues (including feeding difficulties). For children with coordination and motor difficulties, as well as medical conditions associated with motor impairments (e.g., cerebral palsy), **physical therapy** and/or consultation with a physical medicine and rehabilitation (PM&R) specialist may be recommended. Speech, occupational, and physical therapy services will typically require a prescription from the child's primary care provider.

Children with ASD and their families often benefit from supports in the home and community in addition to behavioral treatment and/or other therapeutic interventions. The following are common ancillary support services that should be considered for necessity:

- **Community living supports (CLS) services** are provided in home or community settings to help increase an individual's development of independence skills, support progress toward goals, and promote inclusion in the community through skills training and personal assistance. When recommending CLS services, evaluators are encouraged to describe key domains for functional skills training and targets for interventions.
- **Respite services** provide a break to the child's caregivers by having a paid adult (through a local agency or a friend/family member) care for the child for short periods. Respite services may be beneficial for many families of children and youth diagnosed with ASD given the additional stress and demands of caring for this population. Evaluators should provide families information about respite care when appropriate.

When describing CLS and/or respite services in reports or feedback sessions, evaluators should be mindful services cannot overlap for a child and that the amount of intervention and service hours must be medically necessary. Per MDHHS policy, ABA services and other supports must be based on the needs of the child and family and must consider the child's school attendance and other daily activities as documented in the IPOS. In addition, families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month. As such, the combination of ABA services, CLS, and/or respite cannot serve to replace daily parental care and supervision.

## Educational Services

School participation and appropriate educational services, supports, and accommodations are essential for school-aged children and youth. Educational services support a child's progress toward academic goals as well as address communication, motor, self-care, behavioral, and social-emotional needs when applicable. Further, the school is often one of the primary settings for social development and exposure, such as participating in cooperative play and group activities and developing peer relationships. For very young and preschool-aged children, educational services are often beneficial to allow a child access to needed education services through the local school district. Enrollment in an early childhood/preschool program is also often helpful to prepare children who are diagnosed with ASD for formal schooling, provide opportunities for social development, and build early learning skills.

Caregivers are often confused about the distinction between a medical diagnosis of Autism Spectrum Disorder and the certification under the Autism Spectrum Disorder category in the Individual Family Service Plan (IFSP; for children under 3) or Individualized Education Program (IEP). Evaluators should explain the differences between ASD evaluations conducted and school-based evaluations as well as the distinction between a medical diagnosis and educational eligibility of ASD.

Per the Michigan ASD State Plan, effective coordination and collaboration between agencies and service providers, including ABA services, educational services, and medical care, is considered a critical component in supporting individuals with ASD and their families. Per MDHHS guidelines, communication and coordination of care are needed to coordinate treatment and prevent duplication of services. ABA services cannot supplant the need for school attendance and necessary school services. School-aged children must continue to participate in their regularly scheduled school day. Evaluators are encouraged to refer to the guide, "IFSP and IEP Considerations for Students with ASD Receiving Insurance-based Treatment/Intervention, available through the MDHHS website: <https://www.michigan.gov/autism/0,4848,7-294-73929---,00.html>.

It is crucial that supports coordinators read evaluation reports to develop the IPOS and have discussion with families to determine next steps, evaluations, and appointments for the family.

## Parent/Family Support and Community Resources

The goal of the initial diagnostic evaluation and behavioral treatment is to help the child be successful in home, community, and school settings. Further, it is often highly stressful for families to have a child diagnosed with ASD (in some cases, multiple children). Evaluators should consider the needs of the family and make recommendations for appropriate services and additional resources. Services through the community mental health setting may include a parent support partner (PSP), which is a service authorized through the child's IPOS that provides peer-to-peer support to parents/caregivers. The PSP is a trained parent with first-hand experience navigating public systems and raising a child with behavioral or emotional difficulties associated with a mental health disorder or developmental disability. Community mental health agencies may also offer parent support groups, educational activities, or recreational programs that can be beneficial to the family.

Evaluators should also direct families to well-supported local, state, and national resources, including advocacy organizations, websites, training programs, and books. The child's supports coordinator is also available to help link the family with services and resources in the area, as well as address financial needs and barriers for the family, such as in housing or transportation.

## Alternative Treatments

Evaluators should be familiar with the range of treatments available and should guide families to intervention methods with strong evidence support. In particular, evaluators should advise parents against treatment methods that have been identified as harmful to children (e.g., chelation, bleach treatment). Evaluators should also discuss the potential risks associated with other alternative treatments with limited empirical support; these risks may include lack of progress, high financial costs, and a waste of time and energy for the child and family. The Association for Science in Autism Treatment (ASAT; [www.asatonline.org](http://www.asatonline.org)) and the National Autism Center's National Standards Project ([www.nationalautismcenter.org/national-standards-project/](http://www.nationalautismcenter.org/national-standards-project/)) provide ongoing updates on various psychological, educational, therapeutic, and biomedical interventions, current research findings, and information about whether an intervention is currently supported by research.

Figure 4.5. Summary of Recommendations for Comprehensive ASD Evaluations

- Clinical Services/Treatment
  - ABA Services
  - Other behavioral therapy
  - Parent skills training and psychoeducation
  - Individual/family therapy (outpatient or home-based)
  - Social skills group
- Medical Recommendations
  - General pediatric monitoring
  - Neurology/genetics
  - Psychiatric referral
  - Evaluation and treatment to address eating or sleep difficulties
  - Vision/hearing screening
- Educational Recommendations
  - Early On/Early Intervention services (for children under 3)
  - Speech, occupational therapy
  - Social work services/behavioral consultation
  - Environmental considerations (particularly if associated intellectual delays, adaptive deficits, and/or severe challenging behaviors)
  - Supports to address cognitive and learning delays
- Ancillary Services and Community Supports
  - Speech therapy
  - Occupational therapy
  - Physical therapy
  - Community Living Services
  - Respite
  - Parent support partner
  - Addressing barriers for family and linking to community-based programs and assistance (e.g., financial, housing, transportation)
  - Recreational opportunities in the community and through local organizations
- Additional Resources and Supports for the Family
  - Resources and education through local, state, and national organizations
  - Parent support groups and networking opportunities (in person and online)

## **Recommendations and Treatment Considerations when Child Does Not Qualify for an ASD Diagnosis**

As emphasized in Chapter 3, evaluators are responsible for determining the appropriate services and supports for a child regardless of whether the child qualifies for an ASD diagnosis and meets medical necessity criteria for ABA services. When an individual does not qualify for a particular service (such as ABA), specific recommendations are even more essential to address the family's concerns and help the individual improve in needed areas (Schneider et al., 2018). Even if ABA services are not warranted, evaluators are still in a strong position to help the child and family and to recommend needed services and supports.

Evaluators must be familiar with the range of services and supports available in their region to address possible differential diagnoses and areas of difficulty, such as developmental delays, language disorders, intellectual disabilities, behavioral or emotional disorders, trauma and/or environmental stressors. If evaluators do not have the appropriate knowledge or skills needed to assess for differential diagnoses and make appropriate recommendations for these issues, they should refer the child to another qualified provider *prior* to completing the evaluation (see Chapter 3). Additionally, evaluators are strongly encouraged to seek consultation with supervisors or colleagues when faced with less familiar diagnostic presentations (e.g., trauma, psychosis) to aid in assessing for possible differential diagnoses and making appropriate recommendations.

## **Chapter 5.**

### **Michigan Autism Services Eligibility & Management for Individuals Receiving ABA**

Medical necessity and the recommendation for ABA services are determined by the evaluator based on the results of the evaluation, including an integration of data about the child's social and behavioral skills, adaptive functioning, and current needs. As was reviewed in Chapter 3, the child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction in order to meet medical necessity criteria. Functional impairment is more than just an ADOS-2 score or diagnosis of Autism Spectrum Disorder. It must be demonstrated that the current impairments associated with the child's ASD diagnosis are best addressed with intensive ABA services. Although ABA treatment will likely be helpful for a range of individuals, not every child diagnosed with ASD is in need of these services.

Following determination of the individual's diagnosis and medical necessity, the evaluator documents the results of the evaluation on the Waiver Support Application (WSA) form, which is then submitted to MDHHS (typically via the local PIHP). This document serves to initiate the process of ABA services for the individual. Evaluators also document the results of re-evaluations and determination of continued need for ABA services through the WSA form on an annual basis.

#### ***Determining Medical Necessity for ABA Services***

Evaluators need to carefully determine, based on the comprehensive evaluation results and the level of current impairment, whether an individual meets medical necessity criteria for ABA services (see Chapter 3 for medical necessity criteria). Evaluators need to be familiar with the range of services and supports available for individuals with ASD through the local PIHP/CMHSP so they can recommend the most appropriate level of care for the child. Recommendations for services should be based on the child's current functioning level and need for intensive behavioral intervention, rather than on single data points (such as the ADOS-2 score), family preferences, or recommendations from other providers (such as supports coordinators, school personnel, BCBAs, etc.).

It is also important that evaluators (when conducting both initial diagnostic evaluations and annual re-evaluations) make decisions for medical necessity independently based on the data and are not unduly influenced by the agency providing ABA services or members of the child's behavioral health team, particularly when the evaluator is employed by the same organization.

Not all individuals diagnosed with ASD require ABA services; the evaluator is responsible for determining medical necessity and the appropriate services based on the child's current level of impairment and needs. This is documented on the WSA form and in the clinical report. The PIHP is responsible for reviewing the WSA form and clinical report regarding the appropriateness of medical necessity and providing ultimate authorization of services.

**Evaluators should consider the following questions when determining medical necessity for ABA services:**

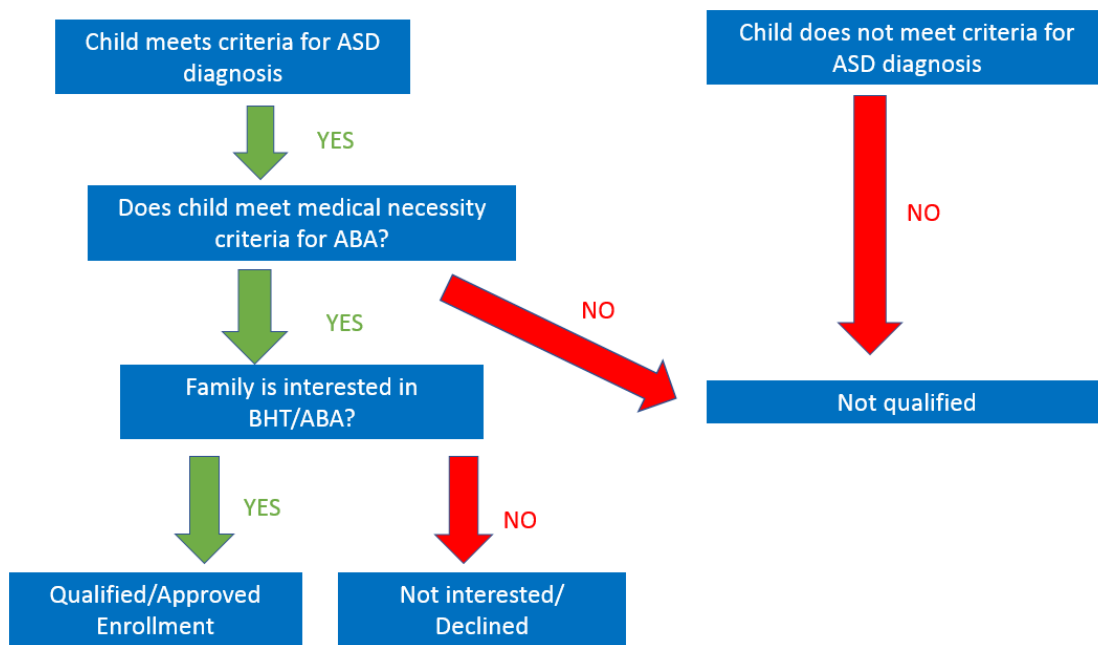
- Are symptoms of ASD currently affecting the child’s functioning in one or more domains (e.g., communication, social behavior, adaptive skills, etc.)?
- Will ABA interventions address the child’s current impairments?
- What will ABA “look like” for the child? What specific skills will be targeted by ABA interventions?  
Is the child able to participate in ABA given other services, including daily school attendance, ancillary services (such as speech therapy), and other supports (e.g., CLS)?
- If child will be receiving home-based ABA, is it possible for the service to be provided in the home given the family’s preferences and current living situation?
- Is there a lower level of care through the local PIHP/CMHSP that will meet the child’s current needs such as CLS?
- Are current impairments related primarily to comorbid diagnoses (e.g., severe intellectual disability, ADHD, trauma symptoms) that may be more appropriately addressed with treatment interventions other than ABA?

Once the evaluator has completed the initial diagnostic evaluation and determined the child meets criteria for an ASD diagnosis and medical necessity for ABA services, the evaluator is responsible for providing feedback to the family as well as the supports coordinator and/or referral source (see Chapter 4). During the feedback session, the evaluator should discuss the recommendation for ABA services. If the family is interested in pursuing ABA, the child will then be enrolled in services. The next step will be the scheduling of the initial behavior assessment by the BCBA, which will include assessment tools such as the Verbal Behavior- Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic Language and Learning Skills- Revised (ABLLS-R), Assessment of Functional Living Skills (AFLS), and/or Autism Curriculum Encyclopedia (ACE) Core Skills Assessment.

The parent/guardian also has the option of declining services ABA services. This may occur when families do not have the resources to participate in this more intensive treatment due to other responsibilities, barriers, and/or family stressors. Note if parent/caregiver is not initially interested in ABA or other services. Some families may also prefer their current treatment provider, such as an outpatient therapy clinician, and feel that this is an appropriate level of care for the child. In other situations, families may seek the initial diagnostic evaluation solely for the purpose of better understanding their child, including obtaining a diagnosis. Evaluators should advise families of their choice in participating in ABA services, choosing an ABA provider, and withdrawing the child from treatment at a later time if desired. Figure 6.1 summarizes the different outcomes that may occur following an initial ASD evaluation:



Figure 1.1. Outcomes and Determining Medical Necessity Criteria for ABA Services



Regardless of the outcome of the evaluation, determination of medical necessity, and family interest in ABA services, the evaluator is responsible for completing the WSA form (see Appendix N for a standard template for the WSA form). It is essential that all required sections of the form are completed and the information about the child is accurate; incomplete data or errors may delay the child’s enrollment and the initiation of ABA services. Figure 5.2 summarizes the responsibilities of the evaluator in determining medical necessity for ABA and communicating the evaluation results to the family, PIHP/CMHSP, and MDHHS.

Figure 5.2. Responsibilities of Evaluator in Determining Medical Necessity for ABA services

- Determine whether child meets criteria for ASD diagnosis
- Determine whether child meets medical necessity criteria for ABA services
- Provide feedback to parent/caregiver regarding child’s diagnosis and treatment recommendations
- If recommending ABA:
  - Clearly explain ABA to the family, the steps for receiving this intervention, and the reason ABA is recommended (including potential treatment targets)
  - Provide parent with information about ABA providers in the area (including the options of center- or home-based providers)
  - Determine the family’s interest in ABA therapy and preference for ABA provider
  - Ensure the caregiver understands the nature of ABA and the responsibilities and demands involved (e.g., several hours per week, parent involvement in training sessions, allowing provider to come to home if receiving home-based services, etc.)
- If not recommending ABA:
  - Clearly explain to parent why ABA is not medically necessary at this time
  - Provide recommendations for other treatment interventions and services
- Complete the WSA form that clearly indicates child’s diagnosis, medical necessity for ABA, and parent’s interest in ABA (when applicable)

## Completion of the WSA Form

Waiver Support Application (WSA) is the enrollment, maintenance, and management tool for the following waivers and programs: Autism (AUT), Children's Waiver Program (CWP), Habilitation Supports (HAB), Health Home Benefit (HHB), Opioid Health Home (HHO), Integrated Care Organization (ICO), MI Care Team Health Home (MIC), and Serious Emotional Disturbance (SED). Results of the initial diagnostic evaluation and annual re-evaluations and determination of medical necessity for ABA are communicated to the PIHP and MDHHS through the WSA form for Autism services, including ABA. A representative of the PIHP creates the case, verifies the initial enrollment information, enters the evaluation details documented on the form, and authorizes services. Upon MDHHS authorization, the case becomes active/current in the AUT application, signaling commencement of Autism Services enrollment and payments. Appendix N includes a standard version of the WSA form that can be modified for regional use. To maintain consistency throughout the state and to ease with data entry, all PIHPs/CMHSPs should utilize a standard version of this form.

Evaluators need to be familiar with the procedures for completing and submitting the WSA form in their agency/region. Evaluators also need to follow the timelines for submission of the form established by their agency/region. It is important to complete form accurately and submit it in a timely manner. Errors in the documentation and failure to submit the form will delay the individual's enrollment and the authorization of funding for ABA services.

The following summarizes the components of the WSA form and instructions for evaluation on how to complete the form accurately:

**Demographic Information:** The top portion of the form includes background information about the individual referred for the evaluation, including the dates of the referral and evaluation, name, age, and Medicaid number. For annual re-evaluations, there typically will not be a referral date. Evaluators are also required to list their PIHP/CMHSP, name and credentials, and the agency/provider where the evaluation was completed.

**Tools Administered:** In this section, the evaluator checks boxes indicating the assessment measures used during the evaluation. At minimum, initial diagnostic evaluations must include an interview of ASD symptoms (ADI-R or equivalent), completion of the ADOS-2, and determination of the DD-CGAS. Annual re-evaluations must include, at minimum, the ADOS-2 and DD-CGAS. *Evaluators are strongly encouraged to use additional assessment tools needed to accurately determine the child's diagnosis, assess for potential differential or comorbid diagnoses, and determine whether the child meets medical necessity criteria for ABA services.* Evaluators should indicate whether cognitive/development testing and assessment of adaptive behavior skills were completed. There is also an "other" category, where evaluators can include other tests administered (e.g., academic achievement testing, language assessment, parent, teacher, or self-report rating scales, etc.).

- Evaluators need to report the overall total of the ADOS-2 score based on the total algorithm items, *not* the comparison score.
- It is essential that the ADOS-2 score is calculated accurately. Evaluators need to follow directions regarding conversion of item codes to algorithm scores (e.g., converting assigned ratings of 3 to algorithm scores of 2).
- When the ADOS-2 cannot be scored (e.g., young child is not yet walking, child presents with vision or hearing impairment), note on the WSA form why the ADOS-2 was not scored (in section where the ADOS-2 is reported and in the notes section).
- The ADOS-2 score is used as a clinical tool and one piece of data that is integrate into the overall clinical impression; the ADOS-2 score alone does not determine diagnosis.

## ***ADOS-2 Score and ADOS-2 Classification/Diagnosis***

Evaluators are required to indicate the module of the ADOS-2 given and report the overall score of the total algorithm items. The evaluator first indicates the module given. Correct identification of the module is crucial given that the raw score can only be interpreted based on the algorithm items that are scored in a particular module.

For the Toddler Module, Module 1, and Module 2, there are two different algorithms based on the child's age and/or language level. For the Toddler Module, the All Younger/Older with Few to No Words algorithm is designated on the WSA form as "Todd A," and the Older with Some Words algorithm is listed as "Todd B." For Module 1, the Few to No Words algorithm is listed as "Mod 1A," and the Some Words algorithm is designated as "Mod 1B." For Module 2, the Younger than Five Years algorithm is listed as "Mod 2A," and the algorithm for Aged 5 Years or Older is listed as "Mod 2B." Module 4, given to older adolescents and young adults, divides the score into 3 parts, Communication, Social Interaction, and Communication + Social Interaction Total. Evaluators should record each of these scores on the WSA form when Module 4 is administered.

After documenting the correct module and score, the evaluator indicates the classification based on the ADOS-2 score (i.e., Autism, Autism Spectrum, Non-Spectrum). These classifications are based on the cutoff scores for each algorithm, which are described for each module on the back page of the ADOS-2 protocol. Individuals who fall below the cutoff score on the ADOS-2 but still meet criteria for a diagnosis of Autism Spectrum Disorder and medical necessity criteria for ABA services are classified as "non-spectrum."

Evaluators also have the option of selecting the box to indicate, "ADOS-2 cannot be scored" in instances when standard administration of the tool could not be completed (e.g., child who was non-ambulatory, when assessing children with visual or hearing impairments, etc.). Evaluators should also describe the specific circumstances why the ADOS-2 could not be administered or scored in the note section on page two of the form.

## ***DD-CGAS Score***

Evaluators need to record the total DD-CGAS score on the WSA form. The DD-CGAS considers a child's current functioning in self-care, communication, social behavior, and academic performance. The DD-CGAS rating should be based on the integration of all data collected in the evaluation, not just on the child's presentation during the observational assessment, overall level of intelligence, or scores on an adaptive behavior questionnaire. The DD-CGAS is required for all individuals assessed for initial diagnostic evaluations and re-evaluations, regardless of their diagnosis or determination of medical necessity for ABA services.

## ***Clinical Diagnosis***

In this section, evaluators note whether the individual met criteria for a clinical diagnosis of Autism Spectrum Disorder and/or other diagnosis. When children do not meet criteria for an ASD diagnosis or ABA services but meet criteria for another diagnosis (e.g., language disorder, intellectual disability ADHD), the appropriate differential diagnosis or diagnoses should be listed. Comorbid diagnoses may also be listed in this area.

## ***Medical Necessity Criteria and Recommendation for ABA Services***

In this section, evaluators mark the DSM-5 diagnostic criteria/medical necessity criteria for the individual. The determination of each criterion should be based on the integration of data, not just on behaviors observed by the evaluator during the ADOS-2. Following the checkboxes of the medical necessity criteria,

the evaluator marks a checkbox indicating whether medical necessity and recommendations for ABA was made by a physician or other licensed qualified practitioner in the State of Michigan.

This item represents the overall opinion of the evaluator regarding the recommendation and need for ABA services. This recommendation should be based on the entirety of the data obtained during the evaluation and the individual's current level of impairment. In cases in which the family is not interested in ABA services, this box should still be checked "yes" if the evaluator is recommending ABA treatment. The family's choice to decline autism services can be indicated in the case action and notes sections below.

### ***Feedback Session Completion***

The WSA form requires evaluators to indicate whether the feedback session was completed, the date of completion, and whether the IPOS supports coordinator.) was present at the feedback session. As emphasized in Chapter 4, completing the feedback session is an essential part of the evaluation process. If the feedback session is still scheduled or attempts have been made to schedule, these should be documented next to the feedback session item and in the notes section.

### ***Additional Comments and Notes***

This section provides an opportunity for evaluators to describe any unusual circumstances that occurred during the evaluation, such as when the ADOS-2 could not be scored or other components of the evaluation could not be completed. Issues related to scheduling, such as no shows, cancellations, or frequent rescheduling of the evaluation and/or feedback session, should also be documented in this section. It is also often helpful to describe the parent's preference in enrolling the child in ABA and reasons that medical necessity for ABA services was or was not supported.

### ***Annual Re-evaluations***

Per the MDHHS Medicaid Provider Manual, an annual re-evaluation by a qualified licensed practitioner (QLP) to assess eligibility criteria for continued ABA services must be conducted. The annual re-evaluations are intended to be helpful updates regarding the individual's functioning and needs. When feasible for the re-evaluation, the family should be given the option of returning to the clinician or clinic who initially conducted their child's ASD evaluation or working with the evaluation team associated with their child's current treatment provider.

At minimum, the annual re-evaluation must include:

- Direct observation of the child and assessment utilizing the ADOS-2;
- Caregiver interview of the individual's current symptoms, emotional and behavioral presentation, current concerns, growth over the past year, and use of services;
- Determination of the child's current level of impairment (DD-CGAS);
- Review of progress in ABA treatment and other interventions;
- Evaluator clinical impressions and recommendations; and
- Feedback to the caregiver.

The responsibilities of the evaluator are the same for both initial diagnostic evaluations and annual re-evaluations. Re-evaluations should be thorough, similar to initial diagnostic evaluations, and review current symptoms, needs, and progress to determine service clinical impressions and recommendations.

Additional tools may be used if needed to determine medical necessity and recommended services. Other tools may include a more extensive clinical interview, cognitive or developmental testing, assessment of adaptive behavior skills, parent and teacher behavior rating scales, and other measures (e.g., assessment of language, academic skills, etc.). Evaluators are also encouraged to review a child's records and obtain information about their goals and progress in ABA treatment (e.g., review results of VB-MAPP/ABLLS-R/AFLS; review three-month reviews of progress; discuss treatment progress with the BCBA/BCaBA, etc.).

At the time of the annual re-evaluation, the evaluator needs to conduct a thorough evaluation to determine whether the child continues to present with significant ASD symptoms and whether medical necessity for ABA services continues to be met based on the child's *current* level of functioning. The evaluation should be as thorough

as is needed to support the child's diagnosis and determine whether the child meets medical necessity criteria for continued ABA services. The recommendations for best practice evaluations and clinical reports that were outlined in Chapters 3 and 4 should still be followed even during annual re-evaluations.

Most importantly, the diagnosis of ASD and determination for medical necessity criteria should *never* be based on one piece of information, such as the ADOS-2 score. As described in Chapter 3, the ADOS-2 requires an estimate of the child's language and intellectual level in order to select the appropriate module and to score the algorithm items. The ADOS-2 is not intended to be used in isolation to make a diagnosis or decisions about services. Evaluators need additional information about the child's current functioning, including response to ABA services and current functioning across home, school, and community settings, to determine whether the child continues to meet medical necessity criteria. Further, the DD-CGAS rating should be based on information about the child's adaptive skills across domains. Information about these domains cannot be obtained through a single observation alone. Rather, information from the parent, review of records, the completion of an adaptive behavior measure, and/or the results of standardized cognitive or developmental testing should be used in combination with direct observations to determine the DD-CGAS score.

Please see Appendix K for a sample re-evaluation report template.

### *Scheduling of Re-evaluations*

Re-evaluation appointments should be scheduled for a similar length of time as initial evaluations in order to include time to interview the caregiver about the child's current functioning and progress in ABA, conduct updated cognitive or developmental testing, complete an adaptive behavior measure, and complete the ADOS-2. Evaluators should work closely with the child's ABA provider and the IPOS supports coordinator to ensure that caregivers are informed of the importance of attending the annual re-evaluation, including being advised that failing to complete the evaluation will affect their child's continued participation in the ABA program. Barriers to attendance should be addressed collaboratively with the evaluator, BCBA/BCaBA/QBHP, supports coordinator, and the family to ensure that the re-evaluation is completed and services are maintained.

The MDHHS Medicaid Provider Manual requires caregiver input, the ADOS-2, and DD-CGAS as a *minimum* for annual re-evaluations. The evaluator is still required to conduct a thorough evaluation, use tools as intended by the test publisher, and determine the diagnosis or diagnoses and medical necessity for ABA services based on an integration of data. Administering the ADOS-2 only is ***not*** sufficient for re-evaluations.

Re-evaluations are required one year following the individual's initial enrollment in ABA services and once a year after as long as enrollment is continued. Authorizations for the re-evaluation should be approved by the PIHP in advance of the one-year deadline to allow for scheduling difficulties (e.g., no shows or cancellations) and to give the evaluator adequate time to complete a thorough evaluation.



Re-evaluations may be completed by the same evaluator who performed the initial diagnostic evaluation. In these situations, evaluators must ensure they conduct a comprehensive re-evaluation and consider the child's current functioning level in making recommendations for services. In some cases, an agency or community mental health provider may include both the ABA treatment service and the evaluation service. It is imperative the behavioral health team and evaluator work independently. Although collaboration and communication between the BCBA/BCaBA/QBHP and evaluator is strongly encouraged in order to learn about the child's functioning, the evaluator should not make a decision on continued services solely based on preferences or recommendations from the behavioral team.

Evaluators are strongly recommended to provide feedback based on the annual re-evaluation results, particularly when the child no longer meets medical necessity criteria for ABA services.

### *Feedback on the Annual Re-evaluation*

As emphasized in Chapter 4, evaluators have a responsibility to provide clear feedback to families based on the results of the assessment, including a review of the data, test procedures, diagnostic impressions, and recommendations. This responsibility also applies to annual re-evaluations, even though these assessments have a different scope and referral reason. At minimum, evaluators need to provide the caregiver with the results of updated assessments and clearly explain whether the child continues to be eligible for ABA services. This feedback may be completed on the same day of the assessment or at a time that is convenient for the family and evaluator. The evaluator is encouraged, in both the feedback session and written report, to identify appropriate targets for intervention based on the current evaluation findings. The results of the evaluation also need to be shared with the BCBA/BCaBA and IPOS supports coordinator, as well as the PIHP and MDHHS (through the completion of the WSA form).

Feedback sessions are essential for re-evaluations even when the child no longer meets medical necessity for ABA services.

Families will be accustomed to these services and often depend on the intensive treatment to address many of their concerns about their child. It is natural that caregivers will experience significant anxiety and stress if these services are discontinued, particularly as there may be a lapse before other services and supports (e.g., outpatient therapy, CLS, respite, etc.) are initiated. In these cases, evaluators should hold a feedback session with the family in which the decision about the child no longer meeting medical necessity criteria is reviewed in detail. In order to support the family and to ensure collaboration among providers, it is often beneficial to include the child's supports coordinator and/or current BCBA/BCaBA/QBHP in the session. Evaluators should discuss specific recommendations for other services, including less intensive modes of treatment that will meet the child's needs. Coordination of care is essential; when appropriate, referrals to medical specialists or other agencies for treatment should be reviewed with the family and supports coordinator to ensure the child transitions to an appropriate level of care.

In the feedback session and clinical report, it is also important for the evaluator to clarify whether the child still is diagnosed with Autism Spectrum Disorder but no longer requires ABA services OR whether the ASD diagnosis is being ruled out completely. When the evaluation results no longer support an ASD diagnosis, the evaluator needs to take particular care to explain why the diagnosis is not being given, why the child may have previously met criteria for the diagnosis, and provide possible differential diagnoses, as well as recommendations for other services that are appropriate for the child's current needs. During the feedback session, the evaluator should also be sure to inform caregivers of their right to seek a second opinion on the diagnosis and/or determination of medical necessity for ABA services.



## Discharge Planning

Evaluators may be involved in decisions to discharge an individual from ABA services, particularly when the determination is made based on the results of the annual re-evaluation.

Per the MDHHS Medicaid Provider Manual, discharge from ABA services is determined by a qualified ABA professional for individuals who meet any of the following criteria:

- The individual will be older than 21.
- The child has achieved treatment goals and less intensive modes of services are medically necessary and appropriate.
- The child is either no longer eligible for Medicaid or is no longer a State of Michigan resident.
- The child has not demonstrated measurable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the ABA interventions are not able to be maintained or they are not replicable beyond the ABA treatment sessions through a period of six months.
- Targeted behaviors and symptoms are becoming persistently worse with ABA treatment over time or with successive authorizations.
- The child no longer meets the eligibility criteria as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.
- The child and/or parent/guardian is not able to meaningfully participate in the ABA services, and does not follow through with treatment recommendations to a degree that compromises the potential effectiveness and outcome of the ABA service.

Discharge planning should be reviewed with the family, behavioral treatment team, and supports coordinator at regular intervals (e.g., formal review of progress). Services may be discontinued at times outside of the annual re-evaluation, assuming the decision was made based on one or more of the criteria above and the family was noticed in advance of the service termination (i.e., through a notice of adverse benefit determination). Families may also choose to withdraw from ABA services or change ABA treatment providers at any time. If individuals are leaving ABA services for any reason, an exit re-evaluation (including the ADOS-2) by a qualified professional is *not* required by MDHHS. However, in coordination with the behavioral treatment team and the IPOS supports coordinator, it may be beneficial to conduct an exit evaluation to make recommendations for services. The PIHP should provide authorization for exit evaluations as needed, even if prior to the one year re-evaluation period if justified medically.

## Second Opinion Evaluations

As is emphasized throughout this manual, conducting diagnostic evaluations for ASD is a complex process that requires a strong training background and examiner expertise. The expanse of age groups (ranging from very young toddlers to young adults) and complex symptom presentations of individuals referred for evaluations and services further complicates the process of diagnosing ASD and making appropriate recommendations for services. Even the most skilled evaluators will be uncertain of the appropriate diagnosis at times and must make the best decision possible based on the information available, the child's developmental level, and their clinical judgment. Research findings have shown there is significant variability among different professionals in making an ASD diagnosis (Williams et al., 2009). In particular, there is disagreement in the diagnosis of ASD when practitioners do not use assessment tools with strong evidence base; inconsistencies among professionals in diagnosing ASD in children from non-English-speaking backgrounds have also been identified (Williams et al., 2009). In addition, well-established tools such as the ADOS-2 and ADI-R may yield inaccurate data with certain symptom presentations, such as ADHD (Grzadzinski et al., 2016).

Given the variability in opinions regarding diagnoses and the complexity of the evaluation process, there will inevitably be situations in which a second opinion evaluation is warranted. Historically, second opinion evaluations (i.e., second opinion requests that are initiated by the patient/client) have been more common in medical settings than in the mental health field (Heuss et al., 2018). The second opinion process has the benefit of ensuring optimal care for the individual and increasing trust with treatment providers (Heuss et al., 2018). Given the level of services associated with intensive ABA, many families will understandably be highly motivated to receive these services, which can typically only be accessed when an individual has a diagnosis of Autism Spectrum Disorder. Caregivers may be upset and frustrated when they feel their child is in need of ABA services and the evaluator determines the child does not qualify. In particular, discontinuing ABA services or ruling out a previous ASD diagnosis based on the annual re-evaluation is often unexpected and distressing for families.

Other factors that may contribute to the seeking of a second opinion include:

- Evaluations that are too short,
- Evaluations that do not include information about a child's functioning outside of the observational assessment,
- Lack of explanation between parent report and clinician observation,
- Poor rapport between the examiner and caregiver, and
- Insufficient communication to the family during the feedback session and/or clinical report.

Even when evaluators follow best practices for completing evaluations and feedback sessions, families may be dissatisfied with the evaluation process or the decisions made based on the evaluation. Per Medicaid guidelines, if the beneficiary requests, the PIHP must provide for

Families are allowed to request second opinion evaluations per MDHHS policy. Information about how to request a second opinion should be provided to families following the initial evaluation.

a second opinion from a qualified health care professional within the network or arrange for the beneficiary to obtain one outside the network, at no cost to the beneficiary. Evaluators as well as the IPOS supports coordinator, should ensure they advise caregivers of their rights in seeking a second opinion and to appeal any decision to deny or change the amount, duration, or scope of a particular service.

## Conducting Second Opinion Evaluations

Per Medicaid guidelines, the PIHP must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition. As such, it is essential that evaluators have the appropriate qualifications and are working within their scope of practice when conducting initial diagnostic evaluations and annual re-evaluations (see Chapter 2).

Further, the PIHP must identify qualified professionals within the network (or outside of the network when needed) who can conduct second opinion evaluations. These individuals should have a high level of expertise and experience in conducting comprehensive ASD evaluations, including strong knowledge of differential and comorbid diagnoses. If evaluators receive a referral for a second opinion evaluation, they should refer the family to a different provider if they do not have the appropriate expertise needed to complete the evaluation or if they have a conflict of interest related to the family (e.g., the evaluator is also the direct treatment provider).

When conducting a second opinion evaluation, determine what questions the caregivers have and what outcome they are seeking. Families are typically seeking clear answers about their child's diagnosis and functioning level, as well as specific recommendations, rather than simply seeking an ASD diagnosis and enrollment into ABA.

When conducting a second opinion evaluation, the guidelines for conducting best practice evaluations for initial diagnostic evaluations should also be followed (see Chapter 3). Regardless of whether the family requested the second opinion evaluation after an initial diagnostic evaluation or based on discontinuation of ABA services following the annual re-evaluation, the second evaluation needs to be comprehensive. Simply conducting portions of the evaluation, such as the ADOS-2, or relying primarily on the opinions and conclusions of the previous evaluator, is *not* recommended. The evaluator will typically review the results of the previous evaluation(s) and the individuals' treatment records in the process of the evaluation, meaning the evaluator will be aware of the previous diagnosis and recommendations. The evaluator still needs to reach an independent decision based on the data collected through the second opinion process. The evaluator should be aware of the test re-administration rules and use alternate measures for assessing cognition and other domains. The feedback session and written report should clearly explain the supporting data for the diagnosis (or rule out of the diagnosis) as well as justification for the recommendations for treatment. Evaluators also complete a WSA form following the second opinion evaluation that clearly indicates the results of the new evaluation and determination whether the individual meets medical necessity criteria.



## **Chapter 6.**

### **Michigan Medicaid Autism Services Myths**

The following is a collection of common myths regarding the Michigan Medicaid Autism Services with factual responses to these myths:

**Myth:** ASD evaluations must occur within 14 days of a request.

**Facts:**

- Evaluations should occur in a timely manner.
- The 14 day mandate rates to initial contact with the child/family which could include intake, supports coordination, development of the Individual Plan of Service, etc.

**Myth:** The ASD evaluation may only be used for diagnosis of ASD and recommending ABA services. You do not have to provide medical necessity service recommendations.

**Facts:**

- Diagnosing clinicians should work within their expertise. We encourage you to consider other appropriate diagnoses and make recommendations about follow-up care as appropriate.
- Remember all children/families coming for an evaluation have concerns and are looking for help as much as, or more than a diagnostic label.

**Myth:** ADOS-2 and ADI-R scores determine ABA eligibility

**Facts:**

- Clinicians diagnosis of ASD, including administration and interpretation of ADOS-2 and clinical recommendation of ASD is required.
- Tools are part of the assessment and alone do not make the ASD diagnosis. The QLPs make the diagnosis.

**Myth:** Medicaid will not cover additional tools such as cognitive/ developmental, adaptive behavior, and/or symptom monitoring. There is a capped rate of reimbursement for evaluations.

**Facts:**

- Clinicians should work closely with their CMH agencies and regional entities to determine allowable services and rates.
- Comprehensive evaluation has always been allowed, including assessment of intellectual and adaptive functioning.
- Clinicians are encouraged to use tools within their expertise that help answer important questions about the youth being served and help plan appropriate treatments.
- If these tools are not in your scope of competence or work, refer to another clinician before making determination of a diagnosis.

**Myth:** You cannot use recent outside evaluations in your eligibility determination.

**Facts:**

- Data from evaluations within the last year can and should be used to avoid unnecessary replication of tests as well as the burden on the family
- You will need to have the score from the ADOS-2 to report ASD medical necessity on the WSA form.
- Unnecessary replication of tests is a burden on the family and wasteful.

Myth: You cannot refer to other Medicaid specialists if you get a case outside your expertise or scope of practice.

Facts:

- Nobody is all-knowing! Your region can help connect you with more experienced or specialized clinicians for special or unclear cases outside your comfort level.
- We routinely share results with the family physician / pediatrician to recommend medical follow-ups, which they can usually coordinate.
- Sometimes a flexible approach may be needed, e.g., we may provisionally diagnose autism, but recommend a hearing evaluation or other workup. The PIHP/CMH agency can work with you to authorize a re-assessment or change in the treatment plan when needed.

Myth: Physicians cannot provide ASD diagnostic evaluations OR physicians can write a prescription for ABA.

Facts:

- Evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD.
- Qualified licensed practitioner includes: physicians, psychologists, advanced practice registered nurses, physician assistants, or clinical social workers with training, experience, or expertise in ASD and/or behavioral health.
- Physicians must follow the same evaluation procedures and use of tools; a prescription does not equal proof of medical necessity.

Myth: Medicaid Autism Services annual re-evaluations are for re-diagnosing ASD

Facts:

- Autism is usually a lifelong condition (although somewhat less than 10% of children who are credibly diagnosed with autism do seem to “grow out of” meeting autism criteria).
- The ADOS-2 is required on re-evaluation. The purpose of re-evaluation is usually not to see if the child “still” has ASD but to make sure the intensive interventions such as ABA are sufficient and/or still most appropriate, if any additional treatments are needed, etc.
- Diagnosing clinicians can also be valuable in helping the family integrate the ABA part of their treatment plan with larger life goals and medical goals for their child.

Myth: The ADOS-2 is the only tool required annually to re-evaluate ABA eligibility.

Facts:

- The ADOS-2 is required but not the only mandate at the annual re-evaluations.
- Other components for re-evaluations:
  - Interview with the caregiver
  - Review of response to intervention (ABA)
  - Other necessary data that will inform treatment
  - As noted, the ADOS-2 does not solely determine eligibility to ABA, but does provide data on ASD presentation and can inform care plans.

Myth: If the child has a low ADOS-2 score during the annual re-evaluation, then ABA is dropped immediately.

Facts:

- Child has coverage through the end of the initial authorization period.
- The ADOS-2 score does not determine eligibility, clinical evaluation does.



Myth: Evaluators conducting re-evaluations should make determinations based solely on the minimally mandated tools and associated scores. You should not consider other factors or seek additional information from others whom provide care or services to the child.

Facts:

- Medical necessity for ABA therapy is determined by the presence of signs and symptoms of autism, as well as by the need for this specific kind of therapy to address needs of the youth.
- Do not just “go by the numbers” but consider the bigger picture.
- If re-evaluation results differ markedly from prior findings, attempt to investigate why this might be the case.

Myth: It is unnecessary to conduct re-evaluation of medical necessity, rate symptoms/core ASD features, and response to treatment annually to inform recs of the child’s plan of service for the upcoming year.

Facts:

- It is **necessary** to conduct re-evaluation of medical necessity, assess symptoms and core ASD features, and response to treatment annually to inform recommendations of the child’s plan of service for the upcoming year.
- Goal of early intervention is change, growth, and development! Our annual re-evaluations assess these areas, in addition to examining medical necessity for ABA.

Myth: There is a specific (e.g., 7, 14, 30 day) timeline requirement for the evaluation report to be completed and uploaded.

Fact:

- There is no specific time line for the evaluation report to be uploaded. The report should be completed in a timely manner with all data from the evaluation incorporated in the clinical impressions and recommendations. There should not be long delays for reports to be completed and uploaded.

Myth: The speed of scheduling and completion of evaluations is a priority over quality and thoroughness of evaluations.

Fact:

- It is imperative that evaluations are done in a comprehensive manner with the most diagnostic certainty possible. Quality and thoroughness are essential.

Myth: Evaluators should be able to complete multiple evaluations in one day and/or a high volume of evaluations per week.

Fact:

- ASD evaluations are complicated and require integration of multiple sources and modes of data, as well as interpretation of qualitative observations. The necessitates time for the evaluator to organize the data, score measures, and write a clear and useful report. Evaluators will need time to do so; without this time, it is likely that more diagnostic errors will occur. Conducting more than one evaluation per day and/or more than five evaluations per week is not recommended.

Myth: You must recommend ABA if you diagnose ASD.

Facts:

- ABA is the most effective therapy form that produces the most benefit in the largest number of children with ASD. However, it is not the only effective tool nor is it the best tool for every specific child.
- Children who are doing very well in the community might need much more targeted ABA help or might be better served through the school system and with other community supports rather than ABA. Some youth with ASD whose primary problems are associated anxiety/depression might be better off in psychotherapy or children’s case management.

- Recommend ABA when it is a good fit for the child's needs and at an intensity that is appropriate to the problem.

Myth: ABA is only effective at 25 hours or more per week.

Facts:

- ABA can be applied many ways:
  - Early Intensive Behavioral Intervention (EIBI) shows best success at 25+ hours
  - ABA hours as needed for skill building
  - ABA hours as needed for problem behaviors
  - Social skills group
  - Parent training models
  - Consultative ABA to inform current care plans
- Hours should be based on:
  - Medical necessity of dose
  - Goals for skill building/behavior targets
  - Family choice and child capacity to participate

Myth: There is a maximum number of hours for ABA for school aged children.

Facts:

- There is a lot of variability in ABA treatment for older children:
  - Some parents and schools can reach agreements, when appropriate to allow for a changed school schedule to facilitate more time in ABA services.
  - Some parents will have increased hours on weekends, school breaks and days off.
  - There is also evidence (e.g., Canisius College's Summermax program) that just a summer of intensive ABA, e.g., 20-40 hours a week during summer recess, for "high functioning" school age children, in a format that allows group interaction with age peers, can be effective even if ABA is not year round.

## References

- Ahern, K. (2000). Something is wrong with my child: A phenomenological account of a search for a diagnosis. *Early Education and Development* 11, 187–200.
- Amaral, D., Geschwind, D., & Dawson, G. (2011). *Autism Spectrum Disorders*. Oxford, England, UK: Oxford University Press.
- American Academy of Pediatrics. (2011). ADHD: Clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. *Pediatrics*, 128(5), 1007-1002. doi:10.1542/peds.2011-2654
- American Academy of Pediatrics. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. *Pediatrics*, 118(1), 405-420.
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: APA.
- American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, Amended June 1, 2010 and January 1, 2017). Retrieved from <http://www.apa.org/ethics/code/index.aspx>
- American Psychological Association. (2001). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: APA.
- Armstrong, C. (2008). AAP releases guideline on identification of children with autism spectrum disorders. *American Family Physician*, 78(11), 1301-1305.
- Austin, A., Katz, T., & Reyes, J.P. (2006). A clinician's guide to providing feedback to families affected by autism. Retrieved from <https://www.autismspeaks.org/tool-kit/atnair-p-guide-providing-feedback-families-affected-autism>.
- Bailey, A., Le Couteur, A., Gottesman, I., Bolton, P., Simonoff, E., Yuzda, E., & Rutter, M. (1995). Autism as a strongly genetic disorder: Evidence from a British twin study. *Psychological Medicine*, 25(1), 63-77.
- Bauman, M.L. (2010). Medical comorbidities in autism: Challenges to diagnosis and treatment. *Neurotherapeutics*, 7(3), 320-327.
- Bekhet, A.K., Johnson, N.L., & Zauszniewski, J.A. (2012). Resilience in family members of persons with autism spectrum disorder: A review of the literature. *Issues in Mental Health Nursing*, 33(10), 650-656.
- Bellini, S. (2006). The development of social anxiety in adolescents With autism spectrum disorders. *Focus on Autism and Other Developmental Disabilities*, 21(3), 138–145.
- Bernard, J. M. & Goodyear, R.K. (2009). *Fundamentals of Clinical Supervision* (4th Ed.). University of Southern California: Pearson.
- Bernier, R., Mao, A., & Yen, J. (2010). Psychopathology, families, and culture: Autism. *Child and Adolescent Psychiatric Clinics*, 19(4), 855-867.
- Berument, S. K., Starr, E., Pickles, A., Tomlins, M., Papanikolaou, K., Lord, C., et al. (2005). Pre-linguistic Autism Diagnostic Observation Schedule adapted for older individuals with severe to profound mental retardation: A pilot study. *Journal of Autism and Developmental Disorders*, 35, 821–829.

- Booth, T., Booth, W., & McConnell, D. (2005a). The prevalence and outcomes of care proceedings involving parents with learning difficulties in the Family Courts. *Journal of Applied Research in Intellectual Disabilities*, 18, 7-17.
- Boyd, B.A. et al. (2010). Sensory features and repetitive behaviors in children with autism and developmental delays. *Autism Research: The official the International Society for Autism Research*, 3(2), 78-87.
- Brereton, A., Tonge, B. & Einfeld, S. J. (2006). Psychopathology in children and adolescents with autism compared to young people with intellectual disability. *Journal of Autism and Developmental Disorders*, 36(7), 863-870.
- Brookman-Frazee, L.I., Drahota, A., & Stadnick, N. (2012). Training community mental health therapists to deliver a package of evidence-based practice strategies for school-age children with Autism Spectrum Disorder: A pilot study. *Journal of Autism and Developmental Disorders*, 42(8), 1651-1661.
- Bruininks, R., Woodcock, R., Weatherman, R., & Hill, B. (1996). *Scales of Independent Behavior-Revised*. Rolling Meadows, IL: Riverside Publishing.
- Burkett, K. et al. (2015). African American families on autism diagnosis and treatment: The influence of culture. *Journal of Autism and Developmental Disorders*, 45(10) 3244-3254.
- Butchart, M. et al. (2017). Autism and visual Impairment: A review of the literature. *Review Journal of Autism and Developmental Disorders*, 4(2), 118-131.
- Capps, L., Yirmiya, N. & Sigman, M. (1992). Understanding of simple and complex Emotions in non-retarded children with autism. *Journal of Child Psychology and Psychiatry* 33, 1169–82
- Cass, H. (1998). Visual impairment and autism: Current questions and future research. *Autism*, 2(2), 117-138.
- Centers for Disease Control and Prevention. (2015). Vaccines Do Not Cause Autism. Retrieved from <https://www.cdc.gov/vaccinesafety/concerns/autism.html>
- Centers for Disease Control and Prevention (2018). Community Report on Autism. Retrieved from <https://www.cdc.gov/ncbddd/autism/addm-community-report/documents/addm-community-report-2018-h.pdf>
- Centers for Disease Control and Prevention. (2012). Prevalence of autism spectrum disorders –Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2008. *Morbidity and Mortality Weekly Report*, 61(SS03), 1-19.
- Centers for Disease Control and Prevention. (2019). Developmental Monitoring and Screening. Retrieved from <https://www.cdc.gov/ncbddd/childdevelopment/screening.html>.
- Charman, T., Swettenham, J., Baron Cohen, S., Cox, A., Baird, G., & Drew, A. (1998). An experimental investigation of social-cognitive abilities in infants with autism: Clinical implications. *Infant Mental Health Journal*, 19(2), 260–275.
- Cohen, H., Amerine-Dickens, T., & Smith, T. (2006). Early intensive behavioral treatment: Replication of the UCLA model in a community setting. *Journal of Developmental and Behavioral Pediatrics*, 27(2), 145-155.
- Courchesne, V., Girard, D., Jacques, C., & Soulieres, I. (2019). Assessing intelligence at autism diagnosis: Mission impossible? Testability and cognitive profile of autistic preschoolers. *Journal of Autism and Developmental Disorders*, 49(3), 845-856.

- Couture, S. M., Penn, D. L., Losh, M., Adolphs, R., Hurley, R., & Piven, J. (2010). Comparison of social cognitive functioning in schizophrenia and high functioning autism: More convergence than divergence. *Psychological Medicine*, 40(4), 569–579.
- Daniels, A.M., Rosenberg, R.E., Law, J.K., Lord, C., Kaufmann, W.E., & Law, P.A. (2011). Stability of initial autism spectrum disorder in community setting. *Journal of Autism and Developmental Disorders*, 41(1), 110-121.
- Davidson, C., O'Hare, A., Mactaggart, F., Green, J., Young, D., Gillberg, C., & Minnis, H. (2015). Social relationship difficulties in autism and reactive attachment disorder: Improving diagnostic validity through structured assessment. *Research in Developmental Disabilities*, 40, 63–72.
- de Bildt, A. et al. (2015). Autism Diagnostic Interview-Revised (ADI-R) Algorithms for Toddlers and Young Preschoolers: Applications in a Non-US Sample of 1,104 Children. *Journal of Autism and Developmental Disorders*, 45, 2076-2091.
- de Bildt, A. et al. (2004). Interrelationship between Autism Diagnostic Observation Schedule-Generic (ADOS-G), Autism Diagnostic Interview-Revised (ADI-R), and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) classification in children and adolescents with mental retardation. *Journal of Autism and Developmental Disorders*, 34(2), 129-137.
- de Bildt, A., Sytema, S., Meffert, H., & Bastiaansen, J.A. (2016). The Autism Diagnostic Observation Schedule, Module 4: Application of the revised algorithms in an independent, well-defined, Dutch sample (n = 93). *Journal of Autism and Developmental Disorders*, 46, 21–30.
- De Lacy, N., & King, B.H. (2013). Revisiting the relationship between autism and schizophrenia: Toward an integrated neurobiology. *Annual Review Clinical Psychology*, 9, 555-587.
- DeStefano, F., Bhasin, T.K., Thompson, W.W., Yeargin-Allsopp, M., & Boyle, C. (2004). Age at first measles-mumps-rubella vaccination in children with autism and school-matched control subjects: A population-based study in metropolitan Atlanta. *Pediatrics*, 113(2), 1-5.
- Drysdale, H., Van Der Meer, L., & Kagohara, D. (2015). Children with autism spectrum disorder for bilingual families: A systematic review. *Review of Autism and Developmental Disorders*, 2(1), 26-38.
- Durkin, M.S. et al. (2008). Advanced Parental Age and the Risk of Autism Spectrum Disorder. *American Journal of Epidemiology*, 168(11), 1268-1276.
- Eaves, L.C., Wingert, H., & Ho, H.H. (2006). Screening for autism: Agreement with diagnosis. *The National Autistic Society*, 10(3), 229-242.
- Eldevik, S., Hastings, R.P., Hughes, J.C., Jahr, E., Eikeseth, S., & Cross, S. (2009). Meta-Analysis of Early Intensive Behavioral Intervention for Children with Autism. *Journal of Clinical Child & Adolescent Psychology*, 38(3), 439-450.
- Ennis-Cole, D., Durodoye, B.A., & Harris, H.L. (2013). The Impact of Culture on Autism Diagnosis and Treatment: Considerations for Counselors and Other Professionals. *The Family Journal: Counseling and Therapy for Couples and Families*, 21(3). 279-287.
- Folstein, S.E., & Rosen- Sheidley, B. (2001). Genetics of autism: complex aetiology for a heterogeneous disorder. *Nature Reviews Genetics*, 2, 943-955.
- Fombonne, E. (2005). The changing epidemiology of autism. *Journal of Applied Research in Intellectual Disabilities*, 18, 281-294.
- Ghandour, R.M. et al. (2018). Prevalence and treatment of depression, anxiety and conduct problems in US children. *Journal of Pediatrics*, 206, 256-267.



- Ghaziuddin, M., & Zafar, S. (2008). Psychiatric comorbidity of adults with autism spectrum disorders. *Clinical Neuropsychiatry*, 5(1), 9-12.
- Gillott, A., Furniss, F., & Walter, A. (2001). Anxiety in high-functioning children with autism. *Autism*, 5(3), 277–286.
- Goin-Kochel, R. P., Mackintosh, V. H., & Myers, B. J. (2006). How many doctors does it take to make an autism spectrum diagnosis? *Autism*, 10(5), 439-451. doi:10.1177/1362361306066601
- Goldstein, S., & Ozonoff, S. (2018). *Assessment of Autism Spectrum Disorders*. New York, NY: Guilford Press.
- Goldstein, S., & Schwabach, A.J. (2004). The comorbidity of Pervasive Developmental Disorder and Attention Deficit Hyperactivity Disorder: Results of a retrospective chart review. *Journal of Autism and developmental Disorders*, 34(3), 329-339.
- Gorgens, K.A. (2011) Clinical Interview. In: J.S. Kreutzer, J. DeLuca, & B. Caplan (eds.), *Encyclopedia of Clinical Neuropsychology*. New York, NY: Springer.
- Gotham, K., Bishop, S.L., & Lord, C. (2011). Diagnosis of Autism Spectrum Disorders. In D. Amaral, D. Geschwind, & G. Dawson (Eds.), *Autism Spectrum Disorders* (30-43). Oxford, England, UK: Oxford University Press.
- Gotham, K., Unruh, K., & Lord, C. (2015). Depression and its measurement in verbal adolescents and adults with autism spectrum disorder. *Autism: The International Journal of Research and Practice*, 19(4), 491–504.
- Gray, K.M., Tonge, B.J., & Sweeney, D.J. (2008). Using the Autism Diagnostic Interview-Revised and the Autism Diagnostic Observation Schedule with young children with developmental delay: Evaluating diagnostic reliability. *Journal of Autism and Developmental Disorders*, 38(4), 657-667.
- Greenlee, J.L. et al. (2016). Medical and behavioral correlates of depression history in children and adolescents with autism spectrum disorder. *Pediatrics*, 137(2), S105-S114.
- Groth-Marnat, G. (2009). *Handbook of Psychological Assessment*. Hoboken, NJ: Wiley & Sons Publishing.
- Grzadzinski, R., Dick, C., Lord, C. & Bishop, S. (2016). Parent-reported and clinician-observed autism spectrum disorder (ASD) symptoms in children with attention deficit/hyperactivity disorder (ADHD): Implications for practice under DSM-5. *Molecular Autism*, 7(1), 7.
- Harris, B., Barton, E., & Albert, C. (2014). Evaluating autism diagnostic and screening tools for cultural and linguistic responsiveness. *Journal of Autism and Developmental Disorders* 44(6), 1275-1287.
- Harrison, P. L., & Oakland, T. (2015). *Adaptive Behavior Assessment System* (3rd ed.). Torrance, CA: Western Psychological Services.
- Hartley, S. L., Sikora, D. M., & McCoy, R. (2008). Prevalence and risk factors of maladaptive behaviour in young children with Autistic Disorder. *Journal of Intellectual Disability Research : JIDR*, 52(10), 819–829.
- Haruvi-Lamdan, N., Horesh, D., & Golan, O. (2018). PTSD and autism spectrum disorder: Co-morbidity, gaps in research, and potential shared mechanisms. *Psychological Trauma: Theory, Research, Practice and Policy*, 10(3), 290-299.
- Hattier, M.A., Matson, J.L., Tureck, K., & Horovitz, M. (2011). The effects of gender and age on repetitive and/or restrictive behaviors and interests in adults with autism spectrum disorders and developmental disabilities. *Research in Developmental Disabilities*, 32(6), 2346-2351.



- Havdahl, K.A. et al. (2017). The influence of parental concern on the utility of autism diagnostic instruments. *Autism Research*, 10(10), 1672-1686.
- Hollomotz, A. (2018). Successful interviews with people with intellectual disability. *Qualitative Research*, 18(2), 153-170.
- Hoover, D.W. (2015). The effects of psychological trauma on children with autism spectrum disorders: A research review. *Review Journal of Autism and Developmental Disorders*, 2(3), 287-299.
- Howlin, P., Magiati, I., & Charman, T. (2009). Systematic review of early intensive behavioral interventions for children With autism. *American Journal on Intellectual and Developmental Disabilities*, 114(1), 23-41.
- Huerta, M., & Lord, C. (2012). Diagnostic evaluations of autism spectrum disorders. *Pediatric Clinics of North America*, 59(1), 103-111.
- Hurtig, T. et al. (2009). Multi-informant reports of psychiatric symptoms among high-functioning adolescents with Asperger syndrome or autism. *Autism: The International Journal of Research and Practice*, 13(6), 583-598.
- Ireton, H. (1992). *Child Development Inventory Manual*. Minneapolis, MN: Behavior Science Systems, Inc.
- Jacobsen, J.W., & Ackerman, L.J. (1990). Differences in adaptive functioning among people with autism or mental retardation. *Journal of Autism and Developmental Disorders*, 20(2), 205-219.
- Jain, A., Marshall, J., Buikema, A., Bancroft, T., Kelly, J.P., & Newschaffer, C.J. (2015). Autism occurrence by MMR vaccine status among US children with older siblings with and without autism. *Journal of American Medical Association*, 313(15), 1534-1540.
- Ji, N. Y., & Findling, R. L. (2015). An update on pharmacotherapy for autism spectrum disorder in children and adolescents. *Current Opinion in Psychiatry*, 28(2), 91-101.
- Joseph, R.M., Tager-Flusberg, H., & Lord, C. (2002). Cognitive profiles and social communicative functioning in children with autism spectrum disorder. *The Journal of Child Psychology and Psychiatry*, 43(6), 807-821.
- Joshi, G., Wozniak, J., Petty, C. et al. (2013). Psychiatric comorbidity and functioning in a clinically referred population of adults with autism spectrum disorders: A comparative study. *Journal of Autism & Developmental Disorders*, 43 (6), 1314-1325. <https://doi.org/10.1007/s10803-012-1679-5>
- Jure, R., Pogonza, R., & Rapin, I. (2016). Autism Spectrum Disorders (ASD) in blind children: Very high prevalence, potentially better outlook. *Journal of Autism and Developmental Disorders*, 46(3), 749-759.
- Kamp-Becker, I., Albertowski, K., Becker, J. et al. (2018). Diagnostic Accuracy of the ADOS and ADOS-2 in clinical practice. *European Child & Adolescent Psychiatry* 27(9), 1193-1207.
- Keller, R. et al. (2015). Diagnostic characteristics of psychosis and autism spectrum disorder in adolescence and adulthood: A case series. *Autism Open Access*, 6(1), 1-4.
- Kenworthy, L., Case, L., Harms, M.B., Martin, A., & Wallace, G.L. (2010). Adaptive behavior ratings correlate with symptomology and IQ among individuals with high functioning autism spectrum disorder. *Journal of Autism and Developmental Disorders*, 40(4), 416-423.
- Kerns, C.S., Newschaffer, C.J., & Berkowitz, S.J. (2015). Traumatic childhood events and autism spectrum disorder. *Journal of Autism and Developmental Disorders*, 45(11), 3475-3486.

- Kleinman, J.M. et al. (2007). Diagnostic stability in very young children with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, 38(4), 606-615.
- Klin A, Chawarska K, Rubin E, Volkmar F. (2004). Clinical assessment of young children at risk for autism. In R. Del Carmen-Wiggins, A. Cater (Eds.), *Handbook of Infant, Toddler, and Preschool Mental Health Assessment* (311–336). Oxford: Oxford Univ. Press.
- Klin, A., Lang, J., Cicchetti ,D.V., & Volkmar, F.R. (2000). Brief report: Interrater reliability of clinical diagnosis and DSM-IV criteria for autistic disorder: Results of the DSM-IV autism field trial. *Journal of Autism and Developmental Disorders*, 30, 163–167
- Krug, D. A., Arick, J. R., & Almond, P. (2008). *Autism screening instrument for educational planning*. Austin, TX: Pro-ed.
- Kuhfeld, M., & Sturm, A. (2018). An examination of the precision of the Autism Diagnostic Observation Schedule using item response theory. *Psychological Assessment*, 30(5), 656-668.
- Landry, S. H., & Loveland, K. A. (1988). Communication behaviors in autism and developmental language delay. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 29(5), 621–634.
- Larson, F. V., Wagner, A. P., Jones, P. B., Tantam, D., Lai, M. C., Baron-Cohen, S., & Holland, A. J. (2017). Psychosis in autism: Comparison of the features of both conditions in a dually affected cohort. *The British journal of psychiatry: the journal of mental science*, 210(4), 269–275.
- Le Couteur, A., Lord, C., & Rutter, M. (2003). *Autism diagnostic interview-revised*. Los Angeles, CA: Western Psychological Services.
- Lee, B.K. et al. (2015). Maternal hospitalization with infection during pregnancy and risk of autism spectrum disorders. *Brain, Behavior and Immunity*, 44, 100-105.
- Lee, D.O., & Ousley, O.Y. (2006). Attention-deficit hyperactivity disorder symptoms in a clinic sample of children and adolescents with pervasive developmental disorders. *Journal of Child Adolescent Psychopharmacology*, 16(6), 737-746.
- Lord, C. (2005). Follow-Up of Two-Year-Olds Referred for Possible Autism. *The Journal of Child Psychology and Psychiatry*, 36(8), 1365-1382.
- Lord, C., Rutter, M., DiLavore, P.C., Risi, S., Gotham, K., & Bishop, S.L. (2012). *Autism diagnostic observation schedule (2<sup>nd</sup> ed.)* [Manual]. Torrance, CA: Western Psychological Services.
- Lord, C., Rutter, M., & Le Couteur, A. (1994). Autism Diagnostic Interview-Revised: A revised version of a diagnostic interview for caregivers of individuals with possible pervasive developmental disorders. *Journal of Autism and Developmental Disorders*, 24(5), 659-685.
- Lord, C., Storoschuk, S., Rutter, M., & Pickles, A. (1993). Using the ADI-R to diagnose autism in preschool children. *Infant Mental Health Journal*, 14(3), 234–252.
- Lugnegård, T., Hallerbäck, M.U., & Gillberg , C. (2011). Psychiatric comorbidity in young adults with a clinical diagnosis of Asperger syndrome. *Research in Developmental Disabilities*, 32, 1910–1917.
- Maddox, B. B., Brodtkin, E. S., Calkins, M. E., Shea, K., Mullan, K., Hostager, J., Mandell, D., & Miller, J. S. (2017). The Accuracy of the ADOS-2 in Identifying Autism among Adults with Complex Psychiatric Conditions. *Journal of autism and developmental disorders*, 47(9), 2703–2709. doi:10.1007/s10803-017-3188-z.
- Magnuson, K.M., & Constantino, J.N. (2011). Characterization of depression in children with autism spectrum disorders. *Journal of Developmental and Behavioral Pediatrics*, 32(4), 332–340.

- Mahoney, A.D. et al. (2013). Autism spectrum disorders and prematurity: A review across gestational age subgroups. *Advances in Neonatal Care*, 13(4), 247-251.
- Mandy, W., Murin, M., & Skuse, D. (2015). The Cognitive Profile in Autism Spectrum Disorders. In M. Leboyer & P. Chaste (Eds.), *Autism Spectrum Disorders: Phenotypes, Mechanisms and Treatments*.
- Marin, L. et al. (2018). Prevalence of schizophrenia spectrum disorder in average-IQ adults with autism spectrum disorders: A meta-analysis. *Journal of Autism and Developmental Disorders*, 48(1), 239-250.
- Matson, J.L., & Nebel-Schwalm, M.S. (2007). Comorbid psychopathology with autism spectrum disorder in children: An overview. *Research in Developmental Disabilities*, 28(4), 341-352.
- Mayes, S. D., Calhoun, S. L., Waschbusch, D. A., & Baweja, R. (2017). Autism and reactive attachment/disinhibited social engagement disorders: Co-occurrence and differentiation. *Clinical Child Psychology and Psychiatry*, 22(4), 620–631.
- Mazefsky, C. A., Kao, J., & Oswald, D. P. (2011). Preliminary evidence suggesting caution in the use of psychiatric self-report measures with adolescents with high-functioning autism spectrum disorders. *Research in autism spectrum disorders*, 5(1), 164–174.
- Mesman, J. & Koot, H.M. (2000). Child- reported depression and anxiety in preadolescents: I. Associations with parent- and teacher-reported problems. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(11), 1371- 1378.
- Miodovnik, A., Harstad, E., Sideridis, G., & Huntington, N. (2015). Timing of the diagnosis of attention deficit/ hyperactivity disorder and autism spectrum disorder. *Pediatrics*, 136(4), e830-e837.
- Mitchell, S. et al. (2006). Early language and communication development of infants later diagnosed with autism spectrum disorder. *Developmental and Behavioral Pediatrics*, 27(2), 69-78.
- Mitchell, S., Cardy, J.O., & Zwaigenbaum, L. (2011). Differentiating autism spectrum disorders from other developmental delays in the first two years of life. *Developmental Disabilities Research Reviews*, 17(2), 130-140.
- Moore, S.J. et al. (2000). A clinical study of 57 children with fetal anticonvulsant syndromes. *Journal of Medical Genetics*, 37(7), 489–497.
- Moretti, M. M., Fine, S., Haley, G., & Marriage, K. (1985). Childhood and adolescent depression: Child-report versus parent-report information. *Journal of the American Academy of Child Psychiatry*, 24(3), 298-302.
- Mossman Steiner, A., Goldsmith, T.A., Snow, A.V., & Chawarska, K. (2012). Practitioner’s guide to assessment of autism spectrum disorders in infants and toddlers. *Journal of Autism and Developmental Disorders*, 42(6), 1183-1196.
- Nader, A.M., & Courchesne, V., Dawson, M., & Soulieres, I. (2014). Does WISC-IV Underestimate the Intelligence of Autistic Children?. *Journal of Autism and Developmental Disorders*, 46(5), 1582-1589.
- National Child Traumatic Stress Network. (2012). The 12 core concepts: Concepts for understanding traumatic stress responses in children and families. doi:10.1037/e501392013-001
- Nissenbaum, M. S., Tollefson N., & Reese, R. M. (2002). The interpretive conference: Sharing a diagnosis of autism with families. *Focus on Autism & Other Developmental Disabilities*, 17(1), 30-43.
- Nordin, V., & Gilberg, C. (1994). The long-term course of autistic disorders: Updates on follow-up studies. *Acta Psychiatrica Scandinavica*, 97(2), 99-108.

- Oliveras-Rentas, R. E., Kenworthy, L., Roberson, R. B., 3rd, Martin, A., & Wallace, G. L. (2012). WISC-IV profile in high-functioning autism spectrum disorders: Impaired processing speed is associated with increased autism communication symptoms and decreased adaptive communication abilities. *Journal of Autism and Developmental Disorders*, 42(5), 655–664.
- Oliver, C., Petty, J., Ruddick, L., & Bacarese-Hamilton, M. (2012). The Association Between Repetitive, Self-Injurious and Aggressive Behavior in Children with Severe Intellectual Disability. *Journal of Autism and Developmental Disorders*, 42(6), 910-919.
- Osbourne, L. A. & Reed, P. (2008). Parents' perceptions of communication with diagnosticians during diagnosis of autism. *Autism*, 12(3), 309–324. doi:10.1177/1362361307089517
- Overton, T., Fielding, C., & Garcia de Alba, R. (2007). Differential diagnosis of Hispanic children referred for autism spectrum disorders: Complex issues. *Journal of Autism and Developmental Disorders*, 37, 1996-2007.
- Rapoport, J., Chavez, A., Greenstein, D., Addington, A., & Gogtay, N. (2009). Autism spectrum disorders and childhood-onset schizophrenia: Clinical and biological contributions to a relation revisited. *Journal of the American Academy of Child and Adolescent Psychiatry*, 48(1), 10–18.
- Rasalam A.D. et al. (2005). Characteristics of fetal anticonvulsant syndrome associated autistic disorder. *Developmental Medicine and Child Neurology*, 47(8), 551–555.
- Ray- Subramanian, C.E., Huai, N., & Ellis-Weismer, S. (2011). Brief report: Adaptive behavior and cognitive skills for toddlers on the autism spectrum. *Journal of Autism and Developmental Disorders*, 41(5), 679-684.
- Robins, D.L. et al. (2009). Modified Checklist for Autism in Toddlers, Revised, with Follow-Up (M-CHAT-R/F). Retrieved from <https://mchatscreen.com/mchat-rf/>
- Rogers, S. J., Hepburn, S., Stackhouse, T., & Wehner, E. (2003). Parent reports of sensory symptoms in toddlers with autism and those with other developmental disorders. *Journal of Autism and Developmental Disorders*, 33(6), 631–642.
- Rosenhall, U., Nordin, V., Sandstrom, M., Ahlsen, G., & Gillberg, C. (1999). Autism and hearing loss. *Journal of Autism and Developmental Disorders*, 29(5), 349-357.
- Rutter, M., Bailey, A., & Lord, C. (2003). *SCQ. The Social Communication Questionnaire*. Torrance, CA: Western Psychological Services.
- Rutter, M., Lecouteur, A., & Lord, C. (2003). *Autism diagnostic interview: Revised*. Torrance, CA: Western Psychological Services.
- Sabapathy, T., Madduri, N., Deavenport-Saman, A., Zamora, I., Schrager, S.M., & Vanderbilt, D.L. (2017). Parent reported strengths in children with autism spectrum disorder as the time of an interdisciplinary diagnostic evaluation. *Journal of Developmental and Behavioral Pediatrics : JDBP*, 38(3), 181-186.
- Sabina, C. Huess, S.C., Schwartz, B.J., & Schneeberger, A.R. (2018). Second opinions in psychiatry: A review. *Journal of Psychiatric Practice*, 24(6), 434,442.
- Sallows, G.O., & Graupner, T.D. (2005). Intensive behavioral treatment for children with autism: Four-year outcome and predictors. *American Journal of Mental Retardation*, 110(6), 417-438.
- Sappok, T. et al. (2013). Diagnosing autism in a clinical sample of adults with intellectual disabilities: How useful are the ADOS and ADI-R? *Research in Developmental Disabilities*, 34(5), 1642-1655.



- Saulnier, C.A., & Ventola, P.E. (2012). *Essentials of Autism Spectrum Disorder Evaluation and Assessment*. New York, NY: Wiley.
- Saunders, B.S. et al. (2015). The financial and employment impact of intellectual disability on families of children with autism. *Family, Systems & Health*, 33(1), 36-45.
- Schneider, J. et al. (2018). *Essentials of Assessment Report Writing* (2<sup>nd</sup> ed.). New York, NY: Wiley.
- Selten, J. P., Lundberg, M., Rai, D., & Magnusson, C. (2015). Risks for nonaffective psychotic disorder and bipolar disorder in young people with autism spectrum disorder: A population based study. *JAMA Psychiatry*, 72(5), 483–489.
- Shattuck, P. T. et al. (2007). Change in autism symptoms and maladaptive behaviors in adolescents and adults with an autism spectrum disorder. *Journal of Autism and Developmental Disorders*, 37, 1735–1747.
- Shea, V. (1993). Interpreting results to parents of preschool children. In Schopler, M. Van Bourgondien, & M. Bristol (Eds.), *Preschool issues in autism* (185-198). New York: Plenum Press.
- Sikora, D.M., Vora, P., Coury, D.L., & Rosenberg, D. (2012). Attention-deficit/hyperactivity disorder symptoms, adaptive functioning and quality of life in children with autism spectrum disorder. *Pediatrics*, 130, S91-S197.
- Simonoff, E. et al. (2008). Psychiatric disorders in children with autism spectrum disorders: Prevalence, comorbidity, and associated factors in a population-derived sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(8), 921-929.
- Skuse, D.H. (2000). Imprinting, the X-Chromosome, and the Male Brain: Explaining Sex Differences in the Liability to Autism. *Pediatric Research*, 1(47), 9.
- Sommers-Flanagan, J. , Abeje Zeleke, W. and Hood, M. H. (2015). Clinical Interview. In R. L. Cautin and S. O. Lilienfeld (Eds.), *The Encyclopedia of Clinical Psychology*. New York, NY: John Wiley & Sons, Inc.
- Sparrow, S.S., Cicchetti, D.V., & Saulnier, C.A. (2016). *Vineland adaptive behavior scales – third edition* [Manual]. Bloomington, MN: Pearson.
- Squires, J. et al. (2009). *Ages & Stages Questionnaires* (3<sup>rd</sup> ed.). Baltimore, MD: Brooks Publishing Co.
- Stadnick, N., Brookman-Frazee, L., Williams, K. N., Cerda, G., & Akshoomoff, N. (2015). A pilot study examining the use of the Autism Diagnostic Observation Schedule in community-based mental health clinics. *Research in Autism Spectrum Disorders*, 20, 39–46.
- Stadnick, N.A., Stahmer, A., & Brookman-Frazee, L. (2015). Preliminary effectiveness of Project ImPACT: A parent mediated intervention for children with autism spectrum disorder delivered in a community program. *Journal of Autism and Developmental Disorders*, 45(7), 2092-2104.
- Stavropoulos, K.K-M., Bolourian, Y., & Blacher, J. (2018). Differential diagnosis of autism spectrum disorder and post traumatic stress disorder: Two clinical cases. *Journal of Clinical Medicine*, 7(4), 71.
- Stone, W.L. et al. (1999). Can autism be diagnosed accurately in children under three years? *Journal of Child Psychology and Psychiatry*, 40, 219–226.
- Szymanski, C.A., Brice, P.J., Lam, K.H., & Hotto, S.A. (2012). Deaf children with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, 42, 2027-2037.

- Szymanski, C.A, Flynn, S., Clark, T. (2014). Dually diagnosed: A retrospective study of the process of diagnosing autism spectrum disorders in children who are deaf and hard of hearing. *Seminars In Speech and Language*, 35(4), 301-308.
- Tarleton, B., Ward, L. & Howarth, J. (2006). *Finding the right support? A review of issues and positive practice in supporting parents with learning difficulties and their children*. London: the Baring Foundation.
- Tasse', M. J., Schalock, R. L., Balboni, G., Bersani, H., Borthwick-Duffy, S. A., Spreat, S. Thissen, D., Widaman, K., & Zhang, D. (2017). *Diagnostic Adaptive Behavior Scale: User's Manual*. Washington, DC: American Association on Intellectual and Developmental Disabilities.
- Taylor, L.E., Swerdfeger, A.L., & Eslick, G.D. (2014). Vaccines are not associated with autism: An evidence-based meta-analysis of case-control and cohort studies. *Vaccine*, 32(29), 3623-3629.
- Teitelbaum, P., Teitelbaum, O., Nye, J., Fryman, J., & Maurer, R. G. (1998). Movement analysis in infancy may be useful for early diagnosis of autism. *Proceedings of the National Academy of Sciences of the United States of America*, 95(23), 13982–13987. doi:10.1073/pnas.95.23.13982
- Tincani, M., Travers, J., & Boutot, A. (2009). Race, culture, and autism spectrum disorder: Understanding the role of diversity in successful educational interventions. *Research & Practice for Persons with Severe Disabilities*, 34(4), 81-90.
- Üstün, T.B.et al. (2010). *Measuring Health and Disability: Manual for WHO Disability Assessment Schedule (WHODAS 2.0)*. Geneva: World Health Organization.
- Vanegas, S. B., Magaña, S., Morales, M., & McNamara, E. (2016). Clinical Validity of the ADI-R in a US-Based Latino Population. *Journal of Autism and Developmental Disorders*, 46(5), 1623–1635.
- Ventola, P. et al. (2007). Differentiating between autism spectrum disorders and other developmental disabilities in children who failed a screening instrument for ASD. *Journal of Autism and Developmental Disorders*, 37(3), 425-436.
- Volkmar, F., Chawarska, K., & Klin, A. (2005). Autism in infancy and early childhood. *Annual Review of Psychology*, 56, 315-336.
- Warren, Z. et al. (2011). A systematic review of early intensive intervention for autism spectrum disorders. *Pediatrics*, 127(5), 1303-1311.
- Wagner, A., Lecavalier, L., Arnold, L.E., Aman, M.G., Scahill, L., Stigler, K.A., Johnson, C., McDougle, C.J., Vitiello, B. (2007). Developmental Disabilities Modification of Children's Global Assessment Scale (DD-CGAS). *Biological Psychiatry*, 61, 504-511.
- White, S. W., Oswald, D., Ollendick, T., & Scahill, L. (2009). Anxiety in children and adolescents with autism spectrum disorders. *Clinical psychology review*, 29(3), 216–229.
- Williams, P.G., & Hersh, J.H. (1997). A male with fetal valproate syndrome and autism. *Developmental Medicine and Child Neurology* 39(9), 632–634.
- Williams, G., King, J., Cunningham, M., Stephan, M., Kerr, B., & Hersh, J.H. (2001). Fetal valproate syndrome and autism: additional evidence of an association. *Developmental Medicine and Child Neurology* 43(3), 202–206.
- World Health Organization(WHO) Report of the Informal Working Group On Prevention Of Deafness And Hearing Impairment Programme Planning. Geneva, 1991.
- Williams, M.E., Atkins, M., & Soles, T. J. (2009). Assessment of Autism in Community Settings: Discrepancies in Classification. *Journal of Autism and Developmental Disorders*, 39(4), 660–669.



- Xiao, Z. et al. (2014). Autism spectrum disorder as early neurodevelopmental disorder: Evidence from brain imaging abnormalities in 2-3 year old toddlers. *Journal of Autism and Developmental Disorders*, 44(7), 1633-1640.
- Zander, E., Sturm, H., & Bölte, S. (2015). The added value of the combined use of the Autism Diagnostic Interview–Revised and the Autism Diagnostic Observation Schedule: Diagnostic validity in a clinical Swedish sample of toddlers and young preschoolers. *Autism*, 19(2), 187–199.
- Zander, E. et al. (2017). The interrater reliability of the Autism Diagnostic Interview-Revised (ADI-R) in clinical settings. *Psychopathology*, 50(3), 219-227.
- Zheng, Z., Zheng, P., & Zou, X. (2018). Association between schizophrenia and autism spectrum disorder: A systematic review and meta-analysis. *Autism Research*, 11(8), 1110-1119.
- Zwaigenbaum, L. et al. (2015). Early intervention for children with autism spectrum disorder under 3 years of age: Recommendations for practice and research. *Pediatrics*, 136(Suppl 1), S60-S81.



# Medicaid Provider Manual

## SECTION 18 – BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS

The purpose of this policy is to provide for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age with Autism Spectrum Disorders (ASD). All children, including children with ASD, must receive EPSDT services that are designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services to correct or ameliorate any physical or behavioral conditions, so that health problems are averted or diagnosed and treated as early as possible.

According to the U.S. Department of Health & Human Services, autism is characterized by impaired social interactions, problems with verbal and nonverbal communication, repetitive behaviors, and/or severely limited activities and interests. Early detection and treatment can have a significant impact on the child's development. Autism can be viewed as a continuum or spectrum, known as ASD, and includes Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (PDDNOS). The disorders on the spectrum vary in severity and presentation but have certain common core symptoms. The goals of treatment for ASD focus on improving core deficits in communication, social interactions, and restricted behaviors. Changing these fundamental deficits may benefit children by developing greater functional skills and independence.

BHT services prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. Medical necessity and recommendation for BHT services is determined by a physician, or other licensed practitioner working within their scope of practice under state law. Direct patient care services that treat or address ASD under the state plan are available to children under 21 years of age as required by the EPSDT benefit.

### 18.1 SCREENING

The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well child visit with the child's primary care provider (PCP). EPSDT well child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well child evaluation is also designed to rule out medical or behavioral conditions other than ASD and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.

### 18.2 REFERRAL

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of

occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed.

After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including ABA) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD who do not meet the eligibility requirements for developmental disabilities by the PIHP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

### **18.3 COMPREHENSIVE DIAGNOSTIC EVALUATIONS**

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment which is provided or supervised by a BCBA to recommend more specific ASD treatment interventions. The diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes:

- a physician with a specialty in psychiatry or neurology;
- a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline;
- a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
- a psychologist;
- an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health;
- a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
- a clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.

The determination of a diagnosis by a qualified licensed practitioner is accomplished by direct observation and utilizing the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2), and by administering a comprehensive clinical interview including a developmental symptom history (medical, behavioral, and social history) such as the Autism Diagnostic Interview-Revised (ADI-R) or clinical equivalent. In addition, a qualified licensed practitioner will rate symptom severity with the Developmental Disabilities Children's Global Assessment Scale (DD-CGAS). Other tools should be used if the clinician feels it is necessary to determine a diagnosis and medical necessity service recommendations. Other tools may include:

- cognitive/developmental tests, such as the Mullen Scales of Early Learning, Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV), Wechsler Intelligence Scale for Children-IV (WISC-IV), Wechsler Intelligence Scale for Children-V (WISC-V), or Differential Ability Scales-II (DAS-II);
- adaptive behavior tests, such as Vineland Adaptive Behavior Scale-II (VABS-II), Adaptive Behavior Assessment System-III (ABAS-III), or Diagnostic Adaptive Behavior Scale (DABS); and/or
- symptom monitoring, such as Social Responsiveness Scale-II (SRS-II), Aberrant Behavior Checklist, or Social Communication Questionnaire (SCQ).

#### **18.4 MEDICAL NECESSITY CRITERIA**

Medical necessity and recommendation for BHT services is determined by a physician or other licensed practitioner working within their scope of practice under state law. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas:

A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:

1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.

B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).
4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).

#### **18.5 DETERMINATION OF ELIGIBILITY FOR BHT**

The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing the ADOS-2 and symptom rating using the DD-CGAS. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who have the developmental capacity to clinically participate in the available interventions covered by BHT services. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS should be given the diagnosis of

ASD. Children who have marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder. The following requirements must be met:

- Child is under 21 years of age.
- Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.
- Child is medically able to benefit from the BHT treatment.
- Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the BHT interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social-communication, increased interactive play/age-appropriate leisure skills, increased reciprocal communication, etc.
- Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individualized Education Plan/Individualized Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).
- Services are able to be provided in the child's home and community, including centers and clinics.
- Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities or may be masked by learned strategies later in life).
- Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.
- A qualified licensed practitioner recommends BHT services and the services are medically necessary for the child.
- Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.

## **18.6 PRIOR AUTHORIZATION**

BHT services are authorized for a time period not to exceed 365 days. The 365-day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a qualified licensed practitioner working within their scope of practice under state law.

## **18.7 RE-EVALUATION**

An annual re-evaluation by a qualified licensed practitioner to assess eligibility criteria must be conducted through direct observation utilizing the ADOS-2 and symptoms rated using the DD-CGAS. Additional tools should be used if the clinician feels it is necessary to determine medical necessity and recommended services. Other tools may include cognitive/developmental tests, adaptive behavior tests, and/or symptom monitoring.

## **18.8 DISCHARGE CRITERIA**

Discharge from BHT services is determined by a qualified BHT professional for children who meet any of the following criteria:

- The child has achieved treatment goals and less intensive modes of services are medically necessary and appropriate.
- The child is either no longer eligible for Medicaid or is no longer a State of Michigan resident.
- The child has not demonstrated measurable improvement and progress toward goals, and the



predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through a period of six months.

- Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations.
- The child no longer meets the eligibility criteria as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.
- The child and/or parent/guardian is not able to meaningfully participate in the BHT services, and does not follow through with treatment recommendations to a degree that compromises the potential effectiveness and outcome of the BHT service.

## **18.9 BHT SERVICES**

### **18.9.A. BEHAVIORAL ASSESSMENT**

Behavioral assessments must use a validated instrument and can include direct observational assessment, observation, record review, data collection, and analysis by a qualified provider. Examples of behavior assessments include function analysis and functional behavior assessments. The behavioral assessment must include the current level of functioning of the child using a validated data collection method. Behavioral assessments and ongoing measurements of improvement must include behavioral outcome tools. Examples of behavioral outcome tools include Verbal Behavior- Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic Language and Learning Skills -Revised (ABLLS-R), and Assessment of Functional Living Skills (AFLS).

### **18.9.B. BEHAVIORAL INTERVENTION**

BHT services include a variety of behavioral interventions which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence. BHT services are designed to be delivered primarily in the home and in other community settings. Behavioral intervention services include, but are not limited to, the following categories of evidence-based interventions:

- Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis);
- Adapting environments to promote positive behaviors and learning while discouraging negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports, stimulus fading);
- Applying reinforcement to change behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction);
- Teaching techniques to promote positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting, chaining, imitation);
- Teaching parents/guardians to provide individualized interventions for their child for the benefit of the child (e.g., parent/guardian implemented/mediated intervention);
- Using typically developing peers (e.g., individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured playgroups, peer social interaction training); and
- Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software).

In addition to the above listed categories of interventions, covered BHT treatment services may also

include any other intervention supported by credible scientific and/or clinical evidence, as appropriate for each individual. Based on the behavioral plan of care which is adjusted over time based on data collected by the qualified provider to maximize the effectiveness of BHT treatment services, the provider selects and adapts one or more of these services, as appropriate for each individual.

### **18.9.C. BEHAVIORAL OBSERVATION AND DIRECTION**

Behavioral observation and direction is the clinical direction and oversight provided by a qualified provider to a lower level provider based on the required provider standards and qualifications regarding the provision of services to a child. The qualified provider delivers face-to-face observation and direction to a lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. This service is for the direct benefit of the child and provides a real time response to the intervention to maximize the benefit for the child. It also informs of any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the behavioral plan of care.

### **18.9.D. TELEPRACTICE FOR BHT SERVICES**

All telepractice services must be prior authorized (i.e., IPOS indicates telepractice as an identified treatment modality for the beneficiary) by the Michigan Department of Health and Human Services (MDHHS). Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services (e.g., access or travel to needed medical services may be prohibitive). Telepractice must be obtained through real-time interaction between the child's physical location (patient site) and the provider's physical location (provider site). Telepractice services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators, and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients, and services provided via telepractice are provided as part of an array of comprehensive services that include inperson visits and assessments with the primary supervising BHT provider. Qualified providers of behavioral health services are able to arrange telepractice services for the purposes of teaching the parents/guardians to provide individualized interventions to their child and to engage in behavioral health clinical observation and direction (i.e. increase oversight of the provision of services to the beneficiary to support the outcomes of the behavioral plan of care developed by the primary supervising BHT provider). Qualified providers of behavioral health services include Board Certified Behavior Analysts (BCBA), Board Certified Assistant Behavior Analysts (BCaBA), Licensed Psychologists (LP), Limited Licensed Psychologists (LLP), and Qualified Behavioral Health Professionals (QBHP). The provider of the telepractice service is only able to monitor one child/family at a time. The administration of telepractice services are subject to the same provision of services that are provided to a patient in person. Providers of telepractice services must be currently certified by the Behavior Analyst Certification Board (BACB), be a QBHP enrolled in a BACB degree program, be licensed in the State of Michigan as a fully licensed psychologist, or be a practitioner who holds a limited license and is under the direction of a fully licensed psychologist. Providers must ensure the privacy of the child and secure any information shared via telemedicine.

The technology used must meet the requirements of audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements.

The patient site may be located within a center, clinic, at the patient's home, or any other established site deemed appropriate by the provider. The room must be free from distractions that would interfere with the telepractice session. A facilitator must be trained in the use of the telepractice technology and be physically present at the patient site during the entire telepractice session to assist the patient at the

direction of the qualified provider of behavioral health. Occupational, physical, and speech therapy are not covered under telepractice services. Refer to the Telemedicine Services database on the MDHHS website for appropriate or allowed telemedicine services that may be covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

### **18.10 BHT SERVICE LEVEL**

BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within their community for an appropriate period of time, depending on the needs of the child and their parents/guardians. Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the child's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings, or to be provided when the child would typically be in school but for the parent's/guardian's choice to home-school their child. Each child's IPOS must document that these services do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the child through a local education agency. The recommended service level, setting(s), and duration will be included in the child's IPOS, with the planning team and the parent(s)/guardian(s) reviewing the IPOS at regular intervals (minimally every three months) and, if indicated, adjusting the service level and setting(s) to meet the child's changing needs. The service level includes the number of hours of intervention provided to the child. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each child and should reflect the goals of treatment, specific needs of the child, and response to treatment. The PIHP's Utilization Management will authorize the level of services prior to the delivery of services.

- **Focused Behavioral Intervention:** Focused behavioral intervention is provided an average of 5-15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
- **Comprehensive Behavioral Intervention:** Comprehensive behavioral intervention is provided an average of 16-25 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).

### **18.11 BHT SERVICE EVALUATION**

As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement. BCBA and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the child's response to treatment and skill acquisition. Ongoing determination of the level of service (minimally every six months) requires evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated with the use of reliable and valid assessment instruments (i.e., VB-MAPP, ABLLS-R, AFLS) and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).

### **18.12 BHT SERVICE PROVIDER QUALIFICATIONS**

BHT services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services. BHT services must be provided under the direction of a BCBA, another appropriately qualified LP or LLP, or a master's prepared QBHP. These services must be provided directly to, or on behalf of, the child by training their parents/guardians, behavior technicians, and BCaBAs to deliver the behavioral interventions. The BCBA and other qualified providers are also responsible for

communicating progress on goals to parents/guardians minimally every three to six months; clinical skill development and supervision of BCaBA, QBHP, and behavior technicians; and collaborating with support coordinators/case managers and the parents/guardians on goals and objectives with participation in development of the IPOS that includes the behavioral plan of care.

### **18.12.A. BHT SUPERVISORS**

#### **Board Certified Behavior Analyst- Doctoral (BCBA-D) or Board-Certified Behavior Analyst (BCBA)**

- Services provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
- License/Certification: Current certification as a BCBA through the BACB. The BACB is the national entity accredited by the National Commission for Certifying Agencies (NCCA).
- Education and Training: Minimum of a master's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB course sequence.

#### **Licensed Psychologist (LP)**

- Must be certified as a BCBA by September 30, 2025.
- Services provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
- License/Certification: LP means a doctoral level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements.
- Education and Training: Minimum of a doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas:
  - » Ethical considerations.
  - » Definitions and characteristics; and principles, processes and concepts of behavior.
  - » Behavioral assessment and selecting interventions outcomes and strategies.
  - » Experimental evaluation of interventions.
  - » Measurement of behavior and developing and interpreting behavioral data.
  - » Behavioral change procedures and systems supports.
- A minimum of one-year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the caseload, progress, and treatment of the child with ASD.

#### **Limited License Psychologist (LLP)**

- Must be certified as a BCBA by September 30, 2025.
- Services provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
- License/Certification: LLP means a doctoral or masters level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements.
- Education and Training: Minimum of a masters degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the BACB coursework categories listed above.
- A minimum of one-year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the caseload, progress, and

treatment of the child with ASD.

### **Board Certified Assistant Behavior Analyst (BCaBA)**

- Services provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
- License/Certification: Current certification as a BCaBA through the BACB. The BACB is the national entity accredited by the NCCA.
- Education and Training: Minimum of a bachelor's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB course sequence.
- Works under the supervision of the BCBA.

### **Qualified Behavioral Health Professional (QBHP)**

- Must be certified as a BCBA by September 30, 2025
- Additionally, must be certified as a BCBA within two years of successfully completing the applied behavior analysis (ABA) graduate coursework.
- Services provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
- License/Certification: A license or certification is not required but is optional.
- Education and Training: QBHP must have one of the following state requirements:
  - » Must be a physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD.
  - » Minimum of a master's degree in a mental-health related field or BACB approved degree category from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. Works within their scope of practice, works under the supervision of a BCBA, and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the BACB identified course work categories listed above.

### **Behavior Technician (BT)**

- Services provided: Behavioral intervention.
- License/Certification: A license or certification is not required.
- Education and Training: Will receive BACB Registered Behavior Technician (RBT) training conducted by a professional experienced in BHT services (BCBA, BCaBA, LP, LLP, and/or QBHP), but is not required to register with the BACB upon completion in order to furnish services.
- Works under the supervision of the BCBA or other professional (BCaBA, LP, LLP or QBHP) overseeing the behavioral plan of care, with minimally one hour of clinical observation and direction for every 10 hours of direct treatment.
- Must be at least 18 years of age; able to practice universal precautions to protect against the transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures and to report on activities performed; and be in good standing with the law. Must be able to perform and be certified in basic first aid procedures and is trained in the IPOS/behavioral plan of care utilizing the person-centered planning process.







## Qualified Licensed Practitioner (QLP) Capacity Form

Name of proposed QLP

Email of proposed QLP

Type of license: (*Attach screen shot of LARA license status page*)

☐ Physician (MD/DO)

Specialty: ☐ psychiatry ☐ neurology ☐ developmental pediatrics ☐ other related discipline

☐ Advanced Practice Registered Nurse (APRN)

☐ Physician's Assistant (PA) *Attach signed supervisor agreement*

☐ Licensed Psychologist (LP)

☐ Limited Licensed Psychologist (LLP) *Attach signed supervisor agreement*

☐ Temporary Limited Licensed Psychologist (TLLP) *Attach signed supervisor agreement*

☐ Licensed Master of Social Work— clinical specialty (LMSW)

Experience with ASD population:

Please describe amount and scope of experience assessing, diagnosing, and treating individuals with Autism Spectrum Disorder



## **Supervision Guidelines for Limited Licensed Psychologists (LLP) and Temporary Limited Licensed Psychologists (TLLP)**

### **Supervision requirements for LLP's:**

Must be supervised by a fully licensed Psychologist (LP)

- If licensed for less than 10 years (excluding any time as a TLLP), supervision must be in person 2 hours per month (minimum)
- If licensed for 10 years or more, supervision must be in person 1 hour per month (minimum)

### **Supervision requirements for TLLP's:**

- Must meet individually and in person with a fully licensed psychologist weekly for a minimum of 4 hours per month, during which all active work functions and records of the supervisee are reviewed
- The experience must be acquired in an organized health care setting; defined as: “an organized governmental entity, nonprofit organization, or a private agency, institution, or organization engaged in the delivery of health care services which provides an opportunity for professional interaction and collaboration with other disciplines, an opportunity to utilize a variety of theories, and an opportunity to work with a broad range of populations and techniques.” (LARA Psychology General Rules R338.2521)





## Michigan Medicaid Autism Services Supervision Attestation

Name of Supervisee:

Type of license:

☐ Limited Licensed Psychologist (LLP) *\*must be supervised by a licensed psychologist*  
Licensed less than 10 years: *Individually and in person for at least 2 hours per month*  
Licensed more than 10 years: *Individually and in person for at least 1 hour per month*

☐ Temporary Limited Licensed Psychologist (TLLP) *\*must be supervised by a licensed psychologist; individually and in person weekly for a minimum of 4 hours per month, during which all active work functions and records of the supervisee are reviewed*

☐ Physician Assistant (PA)  
*Physician supervision of all evaluation services provided*

---

I agree to provide supervision to the above licensed individual as required by appropriate professional Michigan Board Administrative rules.

I attest that I have sufficient training, experience, and expertise in the evaluation of Autism Spectrum Disorder to provide this supervision. I understand that supervision involves participation in the evaluation and/or review of all data and in person discussion regarding evaluation cases. I attest that one or more of the following methods will be utilized in my supervision of the above-mentioned individual for each evaluation:

- ☐ I will be part of evaluation process.
- ☐ I will have direct observation of the child being assessed.
- ☐ I will use live or taped observation of a component of the evaluation in supervision.

My signature on this form and clinical reports designates this level of involvement.

Name & Credential of Supervisor:

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## Current Procedural Terminology (CPT) codes approved for MI Medicaid Autism Services evaluation

<b>CPT Code</b>	<b>Description of CPT code</b>	<b>Required credentials</b>
90791	Psychiatric diagnostic evaluation	LP, LLP, MD, APRN
90792	Psychiatric diagnostic evaluation with medical services	MD, APRN
96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen) with scoring and documentation, per standardized instrument	CMHP
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	CMHP
96113	Each additional 30 minutes (to be billed in conjunction with 96112)	CMHP
96127	Brief emotional/behavioral assessment (e.g., depression inventory, ADHD scale) with scoring and documentation, per standardized instrument	CMHP
96116	Neurobehavioral status examination (clinical assessment of thinking, reasoning and judgment [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]) by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	LP, LLP, MD, APRN
96121	Each additional hour (to be billed in conjunction with 96116)	LP, LLP, MD, APRN
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treating planning and report, and interactive feedback to the patient, family member(s), or caregiver(s); first hour	LP, LLP, MD, QMHP
96131	Each additional hour (to be billed in conjunction with 96130)	LP, LLP, MD, QMHP
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treating planning and report, and interactive	LP, LLP, MD, QMHP

	feedback to the patient, family member(s), or caregiver(s); first hour	
96133	Each additional hour (to be billed in conjunction with 96132)	LP, LLP, MD, QMHP
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, 2 or more tests, any method; first 30 minutes	LP, LLP, MD, QMHP
96137	Each additional 30 minutes (to be billed in conjunction with 96136)	LP, LLP, MD, QMHP
96138	Psychological or neuropsychological test administration and scoring by technician, 2 or more tests, any method; first 30 minutes	LP, LLP, MD, QMHP
96139	Each additional 30 minutes (to be billed in conjunction with 96138)	LP, LLP, MD, QMHP
H0031	Assessment by non-physician (including ADI-R/ASD interview, ADOS-2); encounter code	QMHP, BCBA

Physician consultation codes

New patient: 99201, 99202, 99203, 99204, 99205

Return patient: 99211, 99212, 99213, 99214, 99215

Samples for CPT coding of ASD evaluations:

Autism evaluation, *without* cognitive or adaptive assessment completed (e.g., clinical interview, ADOS-2, DD-CGAS):

- 90791 (1 unit)
- 96136 (1 unit)
- 96137 (1 - 4 units)
- 96130 (1 unit)
- 96131 (1 - 2 units)

Autism evaluation as part of a comprehensive psychological evaluation, *with* cognitive and adaptive assessment completed and assessment of comorbid conditions:

- 90791 (1 unit)
- 96136 (1 unit)
- 96137 (1 – 11 units)
- 96130 (1 unit)
- 96131 (1 – 4 units)

Autism evaluation as part of a comprehensive psychological evaluation, *with* cognitive and adaptive assessment completed and assessment of comorbid conditions, *with testing completed in-part by a technician or masters-level provider working under the guidance and supervision of a fully licensed psychologist or physician:*

- 90791 (1 unit)
- 96136 (1 unit)
- 96137 (1 - 11 units)
- 96138 (1 unit)



- 96139 (1 - 7 units)
- 96130 (1 unit)
- 96131 (1 - 4 units)

Autism evaluation as part of a comprehensive neuropsychological evaluation, *with* neurocognitive and adaptive assessment completed and assessment of comorbid conditions:

- 90791 (1 unit)
- 96136 (1 unit)
- 96137 (1 - 15 units)
- 96132 (1 unit)
- 96133 (1 - 5 units)

Autism evaluation as part of a comprehensive neuropsychological evaluation, *with* neurocognitive and adaptive assessment completed and assessment of comorbid conditions, *with testing completed in-part by a technician or masters-level provider working under the guidance and supervision of a fully licensed psychologist or physician:*

- 90791 (1 unit)
- 96136 (1 unit)
- 96137 (1 - 15 units)
- 96138 (1 unit)
- 96139 (1 - 9 units)
- 96132 (1 unit)
- 96133 (1 - 5 units)

Autism evaluation completed by a practitioner other than a psychologist or physician, *with* cognitive and adaptive assessment completed and assessment of comorbid conditions

- 90791 (1 unit)
- H0031 (1 unit)
- 96136 (1 unit)
- 96137 (1-3 units)
- 96130 (1 unit)
- 96131 (1-2 units)

Autism evaluation completed by a practitioner other than a psychologist or physician, *without* cognitive and adaptive assessment completed

- 90791 (1 unit)
- H0031 (1 unit)

Additional helpful notes regarding coding for ASD evaluations:

- For Physicians: 90792 would be used in replacement for 90791 when the clinical interview is completed by a physician with medical services provided
- For Neuropsychologists: 96116 would be used by a licensed psychologist or neuropsychologist, or physician, completing a neurobehavioral exam as part of the evaluation





## Michigan Medicaid Autism Services Supervision Method Form

Name & Credential of Supervisee:

Name of Individual Assessed:

I attest that I have sufficient training, experience, and expertise in the evaluation of Autism Spectrum Disorder to provide this supervision. I understand that supervision involves participation in the evaluation and/or review of all data and in person discussion regarding evaluation cases.

In addition, the following method(s) were utilized in my supervision of the above mentioned supervisee for the above name individual evaluated:

- ☐ I was part of evaluation process.
- ☐ I had direct observation of the child being assessed.
- ☐ I used live or taped observation of a component of the evaluation in supervision.

My signature on this form and clinical reports designates this level of involvement.

Name & Credential of Supervisor:

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## ASD Developmental Symptom History Interview

---

### General Points to Remember When Conducting a Diagnostic ASD Interview

---

- 1) Use good general clinical interviewing skills. To that end, complete a full clinical interview and not just ASD specific questions. Open ended questions that allow the parent/caregiver to teach you about the child are much more fruitful than pointed yes or no questions. Additionally, open ended questions help to protect against reporting bias.
- 2) Remember typical development! This is always the best benchmark in understanding what is abnormal.
- 3) ASD involves symptoms from both the social affective domain and restricted repertoire domain; need to have deficits / symptoms in both areas to make an ASD diagnosis.
- 4) ASD symptoms should be present in the early developmental years, though impairment may not be evident until the social demands exceed the child's capacities. ASD is a neurodevelopmental disorder. If initial symptom onset is in late childhood or adolescence, it is not ASD. Remember that impairment is different than symptoms.
- 5) ASD is not a disorder that varies significantly by environment: you cannot turn it off and turn it on. If symptoms are only present in one environment, it is not ASD. However, there may be fewer demands placed on kids in one setting (home/with family, school) so symptoms may be more apparent or severe in more demanding situations.

*The symptoms below are not to be viewed as appropriate for all kids of all ages—choose the items that best reflect the child's current functioning, and if you ask about symptoms from an earlier developmental stage, make sure the parent or caregiver is responding from that vantage point. For example, you could say, "Think back to your child's second birthday..."*

---

### Social Affective/Communication Skills

---

*\*Remember the focus is on the social use of communication skills given the child's language level*

- Verbal communication skills
  - Level of language skills (single words, phrase speech, fluent sentences)
  - Directed language use (for requesting, social chatting)
  - Conversational skills

- Topical perseveration
  - Lack of reciprocity
  - Literal interpretation of language/poor sense of humor
  - Weak language pragmatics
- Nonverbal communication skills
  - Eye contact
  - Pointing (age of emergence of protoimperative and protodeclarative pointing)
  - Gesture use (instrumental, emotional, descriptive)
  - Joint attention skills (initiation and response)
  - Awareness of nonverbal communication of others
  - Facial expressions utilized for communicative purposes (can you tell how child feels by looking at his/her face, does child use facial expressions to communicate a range of affective experiences)
- Social interest / motivation
  - Engagement with peers
  - Interest in making friends
  - Prefers to be alone vs. with others
- Social awareness
  - Awareness / understanding of emotions of others (response to distress)
  - Orienting toward others
  - Social referencing
- Social responsiveness (quality, consistency by environment, frequency)
  - Response to name
  - Social games (peek-a-boo, duck-duck-goose)
  - Highly motivating situations (preferred activities)
  - Less motivating situations (less preferred activities)
- Social initiation (quality, frequency, related only to strong interests)
  - Requesting\*
  - Play based
  - Surrounding specific topics
  - Sharing
  - Showing
  - Starting conversation
- Poor theory of mind / perspective taking / social prediction skills
- Odd / unusual social behaviors

---

### Restricted Repertoire/Stereotyped Behaviors

---

- Strong interests
  - Odd or unusual interests
  - Consuming by intensity even if developmentally normal interest
  - Topical perseveration
  - Fixation on parts of objects
  - Odd object attachment
  - Level of distress when access to interest area is blocked or removed
- Inflexibility / Repetitive behaviors
  - Difficulty with transitions
  - Rituals
  - Intolerance of change in routines
- Unusual fears / no fear
- Stereotyped language use
  - Delayed echolalia (context congruent and incongruent)
  - Repetitive language
  - Odd intonation
- Hand / body mannerisms (flapping, finger waving, rocking, spinning)
- Aberrant sensory behaviors (hypo- or hyper-sensory response / interest)
- Self-injurious behaviors / severe aggression

---

### Play Behaviors

---

- Functional play skills
- Nonfunctional play (lining up objects, hoarding)
- Creative/ imaginative play skills
- Parallel play
- Reciprocal play
- Range and flexibility in play

---

### Review of Systems/Associated Symptoms

---

- Prenatal history (in utero exposure to prescription medication or substances, etc.)
- Birth history (prematurity, anoxic episode, etc.)
- Developmental milestones / uneven development

- Gross motor / Fine motor
- Receptive language / Expressive language
- Sleep patterns (difficulty initiating or maintaining sleep)
- Eating habits (picky, restricted, repetitive, pica)
- Behavior & mood (compliance, aggression, mood, anxiety)
- Executive skills (attention, impulsivity, activity level, flexibility)
- Toileting skills
- Medical conditions
  - Seizure disorders
  - Allergies / Immune dysfunction
  - Gastrointestinal disorders
  - Motor problems (fine motor, apraxia)
  - Genetic syndromes associated with ASD characteristics

*\*Around 20% of kids will have an identifiable genetic condition associated with ASD characteristics; refer to neurology and genetics*

---

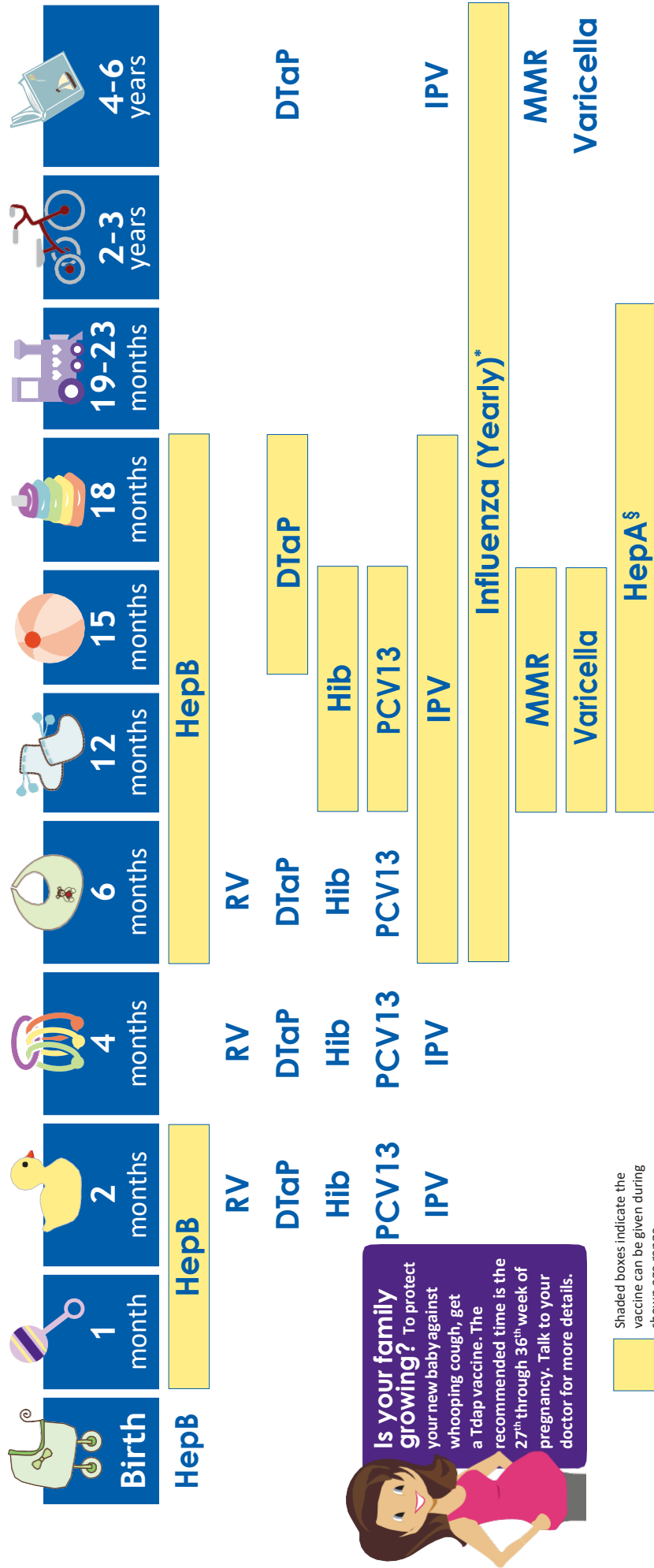
#### High Frequency Rule-Outs

---

- Early childhood deprivation (sometimes seen in kids adopted from Eastern Europe orphanages and with severe neglect during infancy)
- Trauma / Abuse / Attachment issues
- Sensory impairment (deafness, blindness) *\*always suggest vision / hearing test if not completed*
- Language disorder especially when with comorbid anxiety / ADHD
- Severe to profound intellectual disability
- Selective mutism
- Severe social anxiety / OCD
- ADHD (especially with oppositional features)
- Psychosis/prodromal psychosis (negative symptoms, unusual thought patterns, delusional thinking)
- Major depression
- Severe lead poisoning

*\*Always remember that children with ASD frequently present with comorbidities*

## 2019 Recommended Immunizations for Children from Birth Through 6 Years Old



#### NOTE:

If your child misses a shot, you don't need to start over. Just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

#### FOOTNOTES:

\* Two doses given at least four weeks apart are recommended for children age 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.

§ Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 months after the last dose. HepA vaccination may be given to any child 12 months and older to protect against hepatitis A. Children and adolescents who did not receive the HepA vaccine and are at high risk should be vaccinated against hepatitis A.

*If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he or she may need.*

For more information, call toll-free  
**1-800-CDC-INFO (1-800-232-4636)**  
 or visit  
[www.cdc.gov/vaccines/parents](http://www.cdc.gov/vaccines/parents)



**U.S. Department of  
 Health and Human Services**  
 Centers for Disease  
 Control and Prevention



**American Academy  
 of Pediatrics**  
 DEDICATED TO THE HEALTH OF ALL CHILDREN™

See back page for  
 more information on  
 vaccine-preventable  
 diseases and the  
 vaccines that  
 prevent them.





## Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Diseases spread by	Disease symptoms	Disease complications
<b>Chickenpox</b>	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
<b>Diphtheria</b>	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
<b>Hib</b>	Hib vaccine protects against <i>Haemophilus influenzae</i> type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
<b>Hepatitis A</b>	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic and blood disorders
<b>Hepatitis B</b>	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
<b>Influenza (Flu)</b>	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
<b>Measles</b>	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pink eye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
<b>Mumps</b>	MMR** vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord), encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
<b>Pertussis</b>	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
<b>Polio</b>	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death



<b>Pneumococcal</b>	PCV13 vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
<b>Rotavirus</b>	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
<b>Rubella</b>	MMR** vaccine protects against rubella.	Air, direct contact	Sometimes rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
<b>Tetanus</b>	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

\* DTaP combines protection against diphtheria, tetanus, and pertussis.

\*\*MMR combines protection against measles, mumps, and rubella.

Last updated January 2019 • CS300526-A

## INFORMATION FOR PARENTS

## 2019 Recommended Immunizations for Children 7–18 Years Old

**Talk to your child's doctor or nurse about the vaccines recommended for their age.**

	Flu Influenza	Tdap Tetanus, diphtheria, pertussis	HPV Human papillomavirus	Meningococcal		Pneumococcal	Hepatitis B	Hepatitis A	Polio	MMR Measles, mumps, rubella	Chickenpox Varicella
				MenACWY	MenB						
7-8 Years	Green	Orange		Purple		Purple	Orange	Orange	Orange	Orange	Orange
9-10 Years	Green	Orange	Blue/Purple	Purple			Orange	Orange	Orange	Orange	Orange
11-12 Years	Green	Green	Green	Green		Purple	Orange	Orange	Orange	Orange	Orange
13-15 Years	Green	Orange	Orange	Orange		Purple	Orange	Orange	Orange	Orange	Orange
16-18 Years	Green	Orange	Orange	Green/Orange	Blue	Purple	Orange	Orange	Orange	Orange	Orange

**More information:** Everyone 6 months and older should get a flu vaccine every year. All 11- through 12- year olds should get one shot of Tdap. All 11- through 12- year olds should get a 2-shot series of HPV vaccine. A 3-shot series is needed for those with weakened immune systems. All 11- through 12- year olds should get one shot of meningococcal conjugate (MenACWY). A booster shot is recommended at age 16.

These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.



These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.



These shaded boxes indicate the vaccine is recommended for children with certain health or lifestyle conditions that put them at an increased risk for serious diseases. See vaccine-specific recommendations at [www.cdc.gov/vaccines/hcp/acip-recs/](http://www.cdc.gov/vaccines/hcp/acip-recs/).

These shaded boxes indicate the vaccine should be given if a child is catching up on missed vaccines.



These shaded boxes indicate the vaccine should be given if a child is catching up on missed vaccines.



This shaded box indicates children not at increased risk may get the vaccine if they wish after speaking to a provider.

ated with a serogroup B meningococcal (MenB) vaccine.

vacination



U.S. Department of Health and Human Services  
Centers for Disease Control and Prevention



## Vaccine-Preventable Diseases and the Vaccines that Prevent Them

### **Diphtheria** (Can be prevented by Tdap vaccination)

Diphtheria is a very contagious bacterial disease that affects the respiratory system, including the lungs. Diphtheria bacteria can be spread from person to person by direct contact with droplets from an infected person's cough or sneeze. When people are infected, the bacteria can produce a toxin (poison) in the body that can cause a thick coating in the back of the nose or throat that makes it hard to breathe or swallow. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. In serious cases, the illness can cause coma, paralysis, or even death.

### **Hepatitis A** (Can be prevented by HepA vaccination)

Hepatitis A is an infection in the liver caused by hepatitis A virus. The virus is spread primarily person to person through the fecal-oral route. In other words, the virus is taken in by mouth from contact with objects, food, or drinks contaminated by the feces (stool) of an infected person. Symptoms can include fever, tiredness, poor appetite, vomiting, stomach pain, and sometimes jaundice (when skin and eyes turn yellow). An infected person may have no symptoms, may have mild illness for a week or two, may have severe illness for several months, or may rarely develop liver failure and die from the infection. In the U.S., about 100 people a year die from hepatitis A.

### **Hepatitis B** (Can be prevented by HepB vaccination)

Hepatitis B causes a flu-like illness with loss of appetite, nausea, vomiting, rashes, joint pain, and jaundice. Symptoms of acute hepatitis B include fever, fatigue, loss of appetite, nausea, vomiting, pain in joints and stomach, dark urine, grey-colored stools, and jaundice (when skin and eyes turn yellow).

### **Human Papillomavirus** (Can be prevented by HPV vaccination)

Human papillomavirus is a common virus. HPV is most common in people in their teens and early 20s. About 14 million people, including teens, become infected with HPV each year. HPV infection can cause cervical, vaginal, and vulvar cancers in women and penile cancer in men. HPV can also cause anal cancer, oropharyngeal cancer (back of the throat), and genital warts in both men and women.

### **Influenza** (Can be prevented by annual flu vaccination)

Influenza is a highly contagious viral infection of the nose, throat, and lungs. The virus spreads easily through droplets when an infected person coughs or sneezes and can cause mild to severe illness. Typical symptoms include a sudden high fever, chills, a dry cough, headache, runny nose, sore throat, and muscle and joint pain. Extreme fatigue can last from several days to weeks. Influenza may lead to hospitalization or even death, even among previously healthy children.

### **Measles** (Can be prevented by MMR vaccination)

Measles is one of the most contagious viral diseases. Measles virus is spread by direct contact with the airborne respiratory droplets of an infected person. Measles is so contagious that just being in the same room after a person who has measles has already left can result in infection. Symptoms usually include a rash, fever, cough, and red, watery eyes. Fever can persist, rash can last for up to a week, and coughing can last about 10 days. Measles can also cause pneumonia, seizures, brain damage, or death.

### **Meningococcal Disease** (Can be prevented by meningococcal vaccination)

Meningococcal disease has two common outcomes: meningitis (infection of the lining of the brain and spinal cord) and bloodstream infections. The bacteria that cause meningococcal disease spread through the exchange of nose and throat droplets, such as when coughing, sneezing, or kissing. Symptoms include sudden onset of fever, headache, and stiff neck. With bloodstream infection, symptoms also include a dark purple rash. About one of every 10 people who gets the disease dies from it. Survivors of meningococcal disease may lose their arms or legs, become deaf, have problems with their nervous systems, become developmentally disabled, or suffer seizures or strokes.

### **Mumps** (Can be prevented by MMR vaccination)

Mumps is an infectious disease caused by the mumps virus, which is spread in the air by a cough or sneeze from an infected person. A child can also get infected with mumps by coming in contact with a contaminated object like a toy. The mumps virus causes swollen salivary glands under the ears or jaw, fever, muscle aches, tiredness, abdominal pain, and loss of appetite. Severe complications for children who get mumps are uncommon, but can include meningitis (infection of the lining of the brain and spinal cord), encephalitis (inflammation of the brain), permanent hearing loss, or swelling of the testes, which rarely results in decreased fertility.

### **Pertussis** (Whooping Cough) (Can be prevented by Tdap vaccination)

Pertussis spreads very easily through coughing and sneezing. It can cause a bad cough that makes someone gasp for air after coughing fits. This cough can last for many weeks, which can make preteens and teens miss school and other activities. Pertussis can be deadly for babies who are too young to receive the vaccine. Often babies get



whooping cough from their older brothers or sisters, like preteens or teens, or other people in the family. Babies with pertussis can get pneumonia, have seizures, become brain damaged, or even die. About half of children under 1 year of age who get pertussis must be hospitalized.

**Pneumococcal Disease** (Can be prevented by pneumococcal vaccination) Pneumonia is an infection of the lungs that can be caused by the bacteria called “pneumococcus.” These bacteria can cause other types of infections, too, such as ear infections, sinus infections, meningitis (infection of the lining of the brain and spinal cord), and bloodstream infections. Sinus and ear infections are usually mild and are much more common than the more serious forms of pneumococcal disease. However, in some cases, pneumococcal disease can be fatal or result in long-term problems like brain damage and hearing loss. The bacteria that cause pneumococcal disease spread when people cough or sneeze. Many people have the bacteria in their nose or throat at one time or another without being ill—this is known as being a carrier.

#### **Polio** (Can be prevented by IPV vaccination)

Polio is caused by a virus that lives in an infected person’s throat and intestines. It spreads through contact with the stool of an infected person and through droplets from a sneeze or cough. Symptoms typically include sore throat, fever, tiredness, nausea, headache, or stomach pain. In about 1% of cases, polio can cause paralysis. Among those who are paralyzed, about 2 to 10 children out of 100 die because the virus affects the muscles that help them breathe.

**Rubella** (German Measles) (Can be prevented by MMR vaccination) Rubella is caused by a virus that is spread through coughing and sneezing. In children, rubella usually causes a mild illness with fever, swollen glands, and a rash that lasts about 3 days. Rubella rarely causes serious illness or complications in children, but can be very serious to a baby in the womb. If a pregnant woman is infected, the result for the baby can be devastating, including miscarriage, serious heart defects, mental retardation, and loss of hearing and eyesight.

#### **Tetanus** (Lockjaw) (Can be prevented by Tdap vaccination)

Tetanus mainly affects the neck and belly. When people are infected, the bacteria produce a toxin (poison) that causes muscles to become tight, which is very painful. This can lead to “locking” of the jaw so a person cannot open his or her

mouth, swallow, or breathe. The bacteria that cause tetanus are found in soil, dust, and manure. The bacteria enter the body through a puncture, cut, or sore on the skin. Complete recovery from tetanus can take months. One to two out of 10 people who get tetanus die from the disease.

#### **Varicella** (Chickenpox) (Can be prevented by varicella vaccination)

Chickenpox is caused by the varicella zoster virus. Chickenpox is very contagious and spreads very easily from infected people. The virus can spread from either a cough or sneeze. It can also spread from the blisters on the skin, either by touching them or by breathing in these viral particles. Typical symptoms of chickenpox include an itchy rash with blisters, tiredness, headache, and fever. Chickenpox is usually mild, but it can lead to severe skin infections, pneumonia, encephalitis (brain swelling), or even death.



If you have any questions about your child's vaccines, talk to your child's doctor or nurse.

Last updated on January 24, 2019 • CS300526-B



## Autism Spectrum Disorder Assessment by Age: Best Practice

---

### Step One: Establishing the Autism Spectrum Disorder Diagnosis

---

#### General Autism Spectrum Disorder Evaluation Points to Remember

Assessment of Autism Spectrum Disorder (ASD) should be based on multiple data points (direct observation, caregiver interview, test data). The Autism Diagnosis Observation Schedule, Second Edition (ADOS-2) is a very helpful tool in ASD assessment; however, diagnosis of any condition should never be based on one test. Notably, the ADOS-2 provides an instrument classification and not an ASD diagnosis. The Autism Diagnostic Interview-Revised (ADI-R) is a standardized tool to assess for caregiver report of current and past ASD symptoms; again, this is a very helpful tool in ASD assessment. However, the ADI-R does not provide coverage for a full clinical interview, which is a necessary component of any ASD evaluation.

*Ultimately, it is the clinician's expertise with the integration of test, interview, and observational data that yields an accurate diagnosis of ASD.*

It is important that the examiner has a strong understanding of the child's developmental/intellectual and language status to both select the correct module of the ADOS-2, as well as to consider developmental/intellectual functioning when making the clinical diagnosis (ASD or not ASD). The ADOS-2 module selection is based on the expressive language level of the child; scoring of the items is based on consideration of the child's nonverbal mental age. Utilizing a module lower than the child's expressive language level may result in higher rates of false negatives (saying not ASD when the child has ASD) and using a module with higher expressive language demands than what the child exhibits may result in higher rates of false positives (saying ASD when the child does not have ASD).

*Therefore, it is essential that a clinician has accurate information about the child's developmental/intellectual profile prior to administering and scoring the ADOS-2.*

Administering developmental/intellectual and social observational tests to children with ASD can be challenging.

Examiners must:

- Have a minimum of one year of experience working with and assessing children with ASD
- Understand psychometric data
- Be very knowledgeable and comfortable with the appropriate test administration procedures and rules for all tests administered

- Know how to utilize positive reinforcement and differential attending to motivate/shape best testing behaviors during developmental/intellectual assessment
- Most importantly, be able to create a fun, safe, and interesting social environment for the child to show his/her best skills

It is the expectation that the examiner set the battery that is needed to address the question of ASD, as well as to provide some meaningful information for the family irrespective of the individual's ASD status. Compare this to going to the pediatrician with a concern that the child has strep throat and the doctor telling the parent that it is not strep throat and sending the family on their way without feedback or recommendations to manage the child's current symptoms.

It can be difficult for parents/caregivers to learn that their individual has been diagnosed with ASD. Similarly, for a parent/caregiver that has been searching for answers, it can be equally difficult to learn that the individual is not diagnosed with ASD; in this circumstance, it is often helpful to have some information to share with the caregiver about the individual's functioning and some guidance for next steps.

*Evaluations should be helpful to both the family and clinical treatment team. Aside from diagnosis, evaluations should result in meaningful recommendations for the individual's caregivers.*

---

### Very Young Children (age 3 and younger)

---

Developmental functioning is an essential component of ASD evaluation at this age as the symptoms are based on what the child is developmentally capable of exhibiting. Therefore, conducting some manner of developmental and/or adaptive assessment is necessary unless such assessment has already been recently completed and the results are available. Adaptive/developmental assessment should be completed *prior to* the ADOS-2.

The following battery is recommended:

- Clinical interview, including thorough assessment of developmental symptom history (medical, behavioral, and social history [ADI-R or clinical equivalent])
- Developmental evaluation (Mullen Scales of Early Learning, Bayley Scales of Infant Development- Third Edition) *\*unless testing has already been conducted to give an estimate of the child's developmental skill levels, including expressive language, receptive language, and nonverbal skills*
- Adaptive skills (Vineland-3 or similar measure)
- Observational assessment of social behaviors (ADOS-2 & informal)
  - Toddler module: children under 31 months (not yet phrase speakers)
  - Module 1: children 31 months & older speaking primarily single words
  - Module 2: children of *any* age who are fluent, flexible phrase speakers

Other Considerations for this Population

Completing standardized testing with very young children can be difficult. Developmental measures (unlike most intellectual assessment measures) allow for multiple repetition of directions and items unless specifically noted in the manual. Young kids are inconsistent with displaying skills, so patience is necessary. If the child shows significant separation anxiety, which is normative at 12-24 months, the child may perform best with the caregiver in the room.

The ADOS-2 does a good job of differentiating children with Intellectual or Developmental Disability (I/DD) from kids with ASD; however, this relies on the examiner's ability to correctly interpret items within the appropriate developmental context, including verbal and nonverbal skills. For young children with mild to moderate global delay or intellectual disability, research has supported that the lack of use of joint attention behaviors and a flat or declining social and communication trajectory are more often seen in children ASD as compared to kids with I/DD without ASD. Remember that children with intellectual and developmental disabilities have high rates of sensory and repetitive behaviors, so these behaviors in the absence of social affective deficits should not be used to diagnose ASD, though the frequency of motoric symptoms may be higher in kids with ASD. The ADOS-2 is not a good differentiator for children with severe to profound intellectual disability.

*Children in this age range have a good opportunity for a positive response to intervention. Therefore, while treatment of current symptoms is necessary, on-going assessment of symptoms and developmental status is important as the current deficits should not be viewed as the child's long-term status or used for long-term planning.*

---

### Young Children (ages 4 to 6)

---

The following battery is recommended:

- Clinical interview, including thorough assessment of developmental symptom history (medical, behavioral, and social history [ADI-R or clinical equivalent])
- Intellectual/Developmental evaluation (Mullen Scales of Early Learning [MSEL; Note: Mullen norms only go through age 5:5], Wechsler Preschool and Primary Scale of Intelligence, Fourth Ed [WPPSI-IV], Differential Ability Scales, Second Ed [DAS-II] Early Years Battery, Stanford-Binet, Fifth Ed [SB-5])  
*\*unless testing has already been conducted to give an estimate of the child's verbal and nonverbal intellectual status*
- Adaptive skills (Vineland-3 or similar measure)
- Observational assessment of social behaviors (ADOS-2 & informal)

## Other Considerations for this Population

The MSEL and DAS-II Early Years Battery effectively delineate receptive and expressive language skills, as well as provide a solid nonverbal intellectual score. Aside from the one-word receptive language subtest, the Wechsler Preschool and Primary Scale of Intelligence, Fourth Edition (WPPSI-IV) requires verbal responses for an estimate of verbal reasoning skills. Therefore, a Mullen (if not over age 5:5), DAS-II, or other nonverbal measure (e.g., Leiter-3, UNIT-2) may be the best choice for assessment of children with known limited language output.

It can be difficult to select the most appropriate ADOS-2 module for this age range. The following points should be considered when selecting the ADOS-2 module:

- Remember phrase speech must be spontaneous and not only echolalic (immediate or delayed) for the child to be best assessed using module 2.
- Some children in this age range are best assessed using module 3 for fluent sentence speakers; sentences should be complex and communicatively meaningful. Many children begin speaking in basic sentences (“I want a cookie.”) with every now and then uttering a complex sentence (“I went to the store with my mommy.”) before they are truly verbally fluent speakers.
- Further, some children with ASD may be capable of speaking at a level higher than what they typically utilize; however, the selection of the module should be based on the language sample in the ADOS-2, rather than on the best circumstance; developmental/intellectual assessment often helps to guide this decision. For example, if the child is able to say phrases, but does not do so routinely and instead communicates in single words most of the time, the child would be administered module 1.
- *As clearly noted in the ADOS-2 manual, if it is unclear what module the child should receive, go with the module with lower language expectations.*

---

## School Aged Children/Teens/Young Adults of Suspected Intact Intellectual Skills

---

The following battery is recommended:

- Clinical interview (caregiver and teen/young adult), including thorough assessment of developmental symptom history (medical, behavioral, and social history [ADI-R or clinical equivalent])
- Intellectual evaluation (Wechsler Intelligence Scale for Children, Fifth Ed [WISC-V], Differential Ability Scales- Second Ed [DAS-II], Stanford-Binet, Fifth Ed [SB-5], Wechsler Adult Intelligence Scale, Fourth Ed [WAIS-IV])  
*\*unless testing has already been conducted to give an estimate of the individual’s verbal and nonverbal intellectual status*
- Adaptive skills (Vineland-3 or similar)
- Observational assessment of social behaviors (ADOS-2 & informal)





Neuropsychological evaluation (comprehensive and/or targeted) can be helpful in guiding interventions but is not typically necessary for diagnosis of ASD. Individuals with medical complications such as seizure disorders, brain trauma, or extreme prematurity show variable cognitive skills and as such, more comprehensive testing is often helpful.

#### Other Considerations for this Population

The onset and developmental history of symptoms is often a helpful key differentiator. As noted in the DSM-5 criteria, “Symptoms must be present in the early developmental period but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies in later life.”

For intellectually intact individuals, the assessment is often differentiating ASD *from* psychiatric conditions, as well as *with* other psychiatric conditions. Notably, teens and young adults with high-functioning ASD show increased rates of comorbid internalizing disorders.

#### Common Comorbid and Differential Diagnostic Conditions

- Learning Disability/variable Neurocognitive Skills
- Language disorder especially when with comorbid anxiety/ADHD
- Anxiety: Social anxiety/Generalized Anxiety/OCD/Selective Mutism
- Major Depression/Persistent
- ADHD (especially with oppositional features)/ODD/Conduct Disorder
- Psychosis/Prodromal Psychosis (negative symptoms, unusual thought patterns)
- Status Post-Traumatic Brain Injury
- Early childhood deprivation/severe abuse/Reactive Attachment Disorder

---

#### Older Kids/Teens/Young Adults of Suspected Low Intellectual Functioning

---

The following battery is recommended:

- Clinical interview, including thorough assessment of developmental symptom history (medical, behavioral, and social history [ADI-R or clinical equivalent])
- Intellectual evaluation (DAS-II, WISC-V, SB-5, WAIS-IV)  
*\*unless testing has already been conducted to give an estimate of the individual’s verbal and nonverbal intellectual status*
- Adaptive skills (Vineland-3)
- Observational assessment of social behaviors (ADOS-2 & informal)

#### Other Considerations for this Population

For those 18 and over who could *potentially* self-present for the evaluation, it is important to have caregiver report of the individual’s developmental symptom history whenever possible. If



not available, review of educational records, including IEPs and school psychoeducational evaluations, is essential.

The DAS-II has extended norms available that allow for assessment with the early years and/or school aged battery. Age equivalents are given for subtests and a standardized global clinical composite can be generated. For low functioning individuals, the DAS-II is an excellent assessment measure to truly understand the individual's intellectual functioning as the individual may show a floor effect on the WISC-V and WAIS-IV.

Specific nonverbal assessment measures, such as the Leiter-3 or UNIT-2 could be considered for individuals without spoken language.

The ADOS-2 module should be based on language level irrespective of the individual's chronological age. Module 1 or 2 could potentially be the most appropriate module for very low functioning individuals.

See the ADOS-2 manual for further information of administering a lower level module to older children, teens, and young adults. Note that the materials from any module can be used when administering the ADOS-2.

---

#### Step Two:

#### Establishing the Medical Necessity of Applied Behavior Analysis for an Individual with Autism Spectrum Disorder

---

Following establishment of the diagnosis of ASD, the clinician next must determine the medical necessity of Applied Behavior Analysis (ABA) based on a full understanding of the child's symptom profile.

Not all individuals with ASD require ABA intervention. In fact, for some, an ABA treatment approach may not target the symptoms most interfering with the child's functioning.

The evaluation must support the clinical decision that ABA therapy will achieve functional gains beyond those expected as a result of less intensive or other evidence-based intervention or general growth and maturation. There is clear evidence that the symptoms of the ASD are current and resulting in substantial impairment in daily functioning.

ABA may be best utilized for individuals with ASD when:

- Behaviors, social interaction, social communication, adaptive difficulties (toileting, feeding) significantly interfere with home or community activities.

- Behaviors present a health or safety risk to self or others (such as self-injury, aggression toward others, destruction of property, stereotyped/repetitive behaviors, elopement, severe disruptive behavior, etc.).
- Specific targeted behaviors can be defined for improvement, along with measurable, achievable, and realistic goals for improving those behaviors.
- There is evidence from the evaluation that suggests the individual can make behavioral and cognitive gains.
- Less intensive behavior treatment or other evidence-based therapy has been seriously considered or has been applied and has not proven sufficient to reduce interfering behaviors, to increase prosocial behaviors, or to maintain desired behaviors.

Additionally, ABA is expected to be most effective with caregiver involvement. Caregivers should be available and committed to full participation in the program as defined by the person-centered treatment plan. Caregivers should be meaningfully engaged in training and follow through on treatment recommendations beyond that provided by the BCBA or similarly qualified professional who is providing clinical oversight of ABA services of the individual. If caregivers are not willing or able to effectively participate in treatment and ABA is recommended as medically necessary by the evaluator, the clinical evaluation should clearly support the rationale behind the expectation of efficacy of this recommendation.

Recommendation of ABA services should not be made based on comfort or convenience of the child or family in the absence of clinical data to support the recommendation. The child and family should receive intervention methods and settings that are the least intensive based on need and the most appropriate for meeting the defined goals.

As noted in the MDHHS Medicaid Provider Manual, it is the responsibility of the clinician and the clinician's signing clinical doctoral supervisor, if/when applicable, to validate the medical necessity of ABA. If your clinical evaluation suggests that ABA treatment is not likely to effectively address the problematic behaviors, ABA should not be recommended. However, in this situation, the justification for the denial of ABA should be clearly supported in the clinical evaluation report.

A special thanks to Kara Brooklier, Ph.D., Pediatric Neuropsychologist, for her work on developing this best-practice guidance document.



## ASD Evaluation Quality Checklist

The following checklists summarize the requirements from Michigan Medicaid Autism Services and the recommendations for best practice ASD evaluations described in this clinical guideline manual. These checklists may be used for evaluators to monitor their adherence to policy guidelines and best practices. Supervisors and administrators are also encouraged to use these tools to maintain consistency and quality in diagnostic evaluations and reports.

### Checklist for Initial ASD Evaluations:

Components of Evaluation Process	Check when Completed
<i>Prior to Evaluation:</i>	
Evaluators determine they have the necessary expertise and are working within their scope of practice based on the evaluation referral	
Review referral and child's records	
<i>Completing the Evaluation:</i>	
Records and collateral information have been reviewed, including obtaining releases/consent to exchange information when needed	
Clinical interview with caregiver	
ASD-specific interview with caregiver	
Cognitive/developmental testing; language or other assessment measures when needed	
Adaptive behavior assessment	
Observational assessment/ADOS-2	
Other observational data is obtained (e.g., clinical observations during testing)	
Feedback is scheduled with the family	
<i>After the Evaluation</i>	
Evaluator (or evaluation team) scores and interprets measures	
Obtains additional information about child, such as teacher reports, input from the treating providers (e.g., ABA team, speech, OT) or observations in other settings, when needed	
Evaluator discusses evaluation data with supervisor/consults with colleagues or other diagnostic team members	
Evaluator forms diagnostic impressions based on integration of all data collected	
Evaluator determines whether child meets medical necessity criteria for ABA services and determines high-priority recommendations for services	
DD-CGAS is determined; this is documented on the WSA form	
Face-to-face feedback session is completed with caregiver(s), as well as others invited by the family and/or supports coordinator/case manager	
WSA form is completed and submitted	
Comprehensive report is written and uploaded	
Report sent to caregivers	

## Checklist for ASD Evaluation Reports:

Quality Indicators and Components of Report	Check when included in report
<i>Overall Report Quality</i>	
Report is specific to child and referral question, including child's age and developmental level	
Report is well-written and has minimal errors in grammar, spelling, and style	
Report does not include major errors in content (e.g., wrong name, incorrect ADOS-2 score or module, incorrect details about the family)	
<i>Components of Report</i>	
Referral question is clearly stated and is specific to child	
Background section includes relevant information about child's family composition/home environment, developmental and medical history, previous evaluations, services and progress in services, social behavior, and school information	
ASD interview data is summarized, including information about early developmental period and current functioning	
Test results (e.g., developmental/cognitive testing, adaptive behavior assessment) are clearly presented	
Observational data of child throughout the assessment is described	
Observational assessment/ADOS-2 includes the module administered and total ADOS-2 score and clear description of the child's behavior during the assessment	
Clinical formulation/summary includes a summary of the data and diagnostic impressions based on an integration of all data	
Recommendations include interventions for the child, including interventions other than ABA services when appropriate, referrals to medical specialists, other recommended services for the child (e.g., speech, OT), school services and accommodations, supports for the family (e.g., CLS, respite, parent support partner), and additional resources for the family (websites, books, etc.)	
Report is signed by evaluator with correct credentials; supervisor reviews content, provides feedback, and co-signs when needed	





## Sample Report Templates

### Example 1: Initial Diagnostic Evaluation Report Template

#### Confidential Neuropsychological Evaluation

Date of Evaluation:

Name:

Referred By:

DOB:

Examiner:

Case #

Referral Question: r/o Autism Spectrum Disorder (ASD).

#### Background Information:

Allergies

*Medications:*

*Environmental:*

*Foods:*

Current Medications:

Review of Records:

Review of School Records:

Interview:

Family history

Birth history

Medical history

Eating/Nutrition

Sleep info

Therapy history

Self-help skills

School



Social skills

Parental Concerns

Strengths

Observations:

Physical appearance

Motor/gait

Behavior and affect

Speech/language skills

Personal goals/wishes

Response to test structure

Test Results:

Diagnostic Impression:

Formal Diagnoses:

Recommendations:

Follow-up:

CPT Codes/Billing info

CC:

\*\*\*\*\* NEUROPSYCHOLOGICAL TEST SCORES ADDENDUM\*\*\*\*\*



## Example 2: Initial Diagnostic Evaluation Report Template

### CONFIDENTIAL PSYCHOLOGICAL EVALUATION

Name: CHILD Last name

Date of Birth:

Age:

Date of Evaluation:

Examiner:

Case #:

#### Reason for Referral and Relevant Background Information

CHILD Last name is a [age] boy/girl who was referred to [agency name] for a comprehensive psychological evaluation in order to assess for symptoms of Autism Spectrum Disorder (ASD). [Describe reason for referral and referral source] The interview and observational assessment were completed with CHILD's mother/parent/guardian.

*Family Information:*

*Medical History:*

*Developmental History:*

*Previous Evaluations and Treatment:*

Very briefly summarize

*Educational Information:*

#### Procedures

[Describe tests administered, as well as other procedures such as record review, clinical interview with parent, etc.]

#### Test Results

[Description of test scores/ranges (standard scores, t-scores, etc.)]

*Behavioral Observations During Testing*

*Developmental Skill Levels/Cognitive Ability*

Developmental or cognitive testing results

*Adaptive Functioning*

Results of adaptive behavior assessment completed by caregiver (e.g., Vineland-3, ABAS-3)

#### ASD & Behavioral Symptoms

*Parent Interview*

*Social Communication*

- Bullet concerns here

### *Restricted & Repetitive Behaviors*

- Bullet concerns here

### *Associated Behaviors & Emotional Symptoms*

- Bullet concerns here [may include sleep difficulties, feeding issues, hyperactivity, anxiety, etc.]

*[Summary statement about caregiver report on ASD symptoms)*

### *Observational Assessment of ASD Symptoms*

CHILD was administered the ADOS-2 (Module X) to assess his social and communicative behaviors. Results of the semi-structured play observation revealed deficits in his social, communication, and behavioral skills. These deficits were at a level suggestive of Autism (total score = ).

[Summarize ADOS-2...make sure this sounds like the child, not just a list of scored items]

*Overall, CHILD presented with significant social communication deficits and restricted interests and repetitive behaviors. Classification on the ADOS-2 placed him in the Autism range (total score = ).*

### *Global Assessment of Functioning*

The Developmental Disabilities- Children's Global Assessment Scale (DD-CGAS) is a measure for assessing the severity of symptoms and behaviors in children who are identified as having a developmental disability. Functioning in four domains is considered: Self Care, Communication, Social Behavior, and School/Academic. Overall, CHILD's DD-CGAS is currently X, which reflects....

### Clinical Summary and Recommendations

CHILD Lastname is a [age] boy/girl who [summarize referral question].

[Summary of evaluation findings and diagnoses]

### Diagnostic Summary:

DSM-5 Diagnosis:	DSM-5 Code	ICD-10 Code

The following goals should be addressed in CHILD's behavioral treatment plan:

- Put in 3-4 behavioral targets for child based on his/her current functioning level and needs

Based on this evaluation, the following recommendations are advised:



Clinical and Medical Recommendations:

Educational Recommendations:

Additional Recommendations for the Family:

Evaluation results and recommendations were discussed with [Caregiver, anyone else in attendance] in a feedback session on [Date]. Any questions regarding this consultation should be directed to the undersigned.

[Your signature and supervisor signature if needed]

\*\*\*\*\*Appendix: Test Scores Tables\*\*\*\*\*



### Example 3: Annual Re-Evaluation Report Template

#### Confidential Neuropsychological Evaluation

Date of Evaluation:

Referred By:

Examiner:

Name:

DOB:

Case #

Referral Question: Repeat evaluation for Autism Spectrum Disorder (ASD).

Background Information: Firstname was initially evaluated at XXXXXX on DATE by XXXXXX.  
Results of that evaluation revealed...

Allergies

*Medications:*

*Environmental:*

*Foods:*

Current Medications:

Review of School Records:

Interview:

Firstname's family, birth, and prior medical histories were reported previously (DATE), and thus will not be repeated here. In brief, [ADD ANY RELEVANT INFORMATION].

Updates (since last year) regarding family history?

Changes in medical history in last year?

Eating/Nutrition current

Sleep info current

Currently, Firstname attends therapies at

Self-help skills [NEW SKILLS/PROGRESS]

School

Social skills

Parental Concerns



Strengths

Observations:

Physical appearance

Motor/gait

Behavior and affect

Compared to last year [ADD CHANGES/IMPROVEMENTS OBSERVED]

Speech/language skills

Personal goals/wishes

Response to test structure

Test Results:

Diagnostic Impression: Results of this evaluation are consistent with First name's prior evaluation, indicating significant functional problems in the areas of communication, social skills and adaptive abilities, and functional play behaviors, consistent with Autism Spectrum Disorder (ICD-10-CM: F84.0). First name's deficits require substantial support (Level 2) for communication and support (Level 1) for restricted interests and repetitive behaviors.

Recommendations: I strongly recommend that First name continue in with the current school and therapy program at [AGENCY] to receive Applied Behavior Analysis (ABA). First name has apparently made some progress in the past year [ADD PROGRESS], but his/her symptoms of ASD require ongoing intensive ABA therapy.

Follow-up:

CPT Codes/Billing info

CC:

\*\*\*\*\* NEUROPSYCHOLOGICAL TEST SCORES ADDENDUM\*\*\*\*\*





#### Example 4: Annual Re-Evaluation Report Template (Abbreviated Report Example)

### CONFIDENTIAL PSYCHOLOGICAL EVALUATION

Name: XX XX

Date of Birth:

XX/XX/XXXX

Age: XX months, XX months

Date of Evaluation:

#### Reason for Referral and Relevant Background Information

XX XX is a XX-year, XX-month old boy/girl who was referred for annual re-evaluation of his/her developmental skills, adaptive behavior, and Autism Spectrum Disorder (ASD) symptoms. The evaluation is needed to track his/her progress in response to intensive ABA therapy services, determine his/her eligibility for continued ABA services through Michigan Autism Services, and direct treatment planning. The observational assessment and parent interview were completed with XX's mother, Ms. XX.

The following relevant interim history was obtained through a review of XX's records and an interview with his/her mother (or other caregiver). Please refer to XX's initial evaluation (Date) and records for detailed background information and developmental history.

[Briefly describe current family composition and living situation, interim medical information, and other current information about child].

[Briefly summarize previous evaluation results and current treatment (e.g., attends ABA through a center-based program for 15 hours per week)]

[Summarize caregiver's current goals and concerns for child; caregiver's observations of improvements in response to treatment]

[Summarize input provided by the ABA Team, including observations of needs and improvements in response to treatment]

#### Procedures

[Describe tests administered, as well as other procedures such as record review, clinical interview, etc.]

#### *Behavioral Observations During Testing*

#### ASD & Behavioral Symptoms

##### *Parent Interview*

##### *Social Communication Skills*

- Bullet concerns here

##### *Restricted & Repetitive Behaviors*

- Bullet concerns here



#### *Associated Behaviors & Emotional Symptoms*

- Bullet concerns here

*[Summary statement about ASD symptoms based on caregiver report, including noting improvements and progress since the initial/previous evaluation]*

#### *Observational Assessment of ASD Symptoms:*

XX was administered the ADOS-2 (Module X) to assess his social and communicative behaviors. Results of the semi-structured play observation were indicative of...[Describe overall results, including improvements and total ADOS-2 score] The following reflects behaviors observed during the activities that were completed with XX:

#### *Language and Communication*

- Describe relevant observations for this domain

#### *Reciprocal Social Interaction*

- Describe relevant observations for this domain

#### *Stereotyped Behaviors and Restricted Interests*

- Describe relevant observations for this domain

#### *Associated Features*

- Describe relevant observations for this domain

*Overall, XX presented with significantly improved social communication skills and reduced restricted and repetitive behaviors. Classification on the ADOS-2 fell in the...[Describe range] (total score = ).*

#### Clinical Summary and Recommendations

XX XX is a XX-year, XX-month old boy/girl who was referred for annual re-evaluation of his/her developmental skills, adaptive behavior, and Autism Spectrum Disorder (ASD) symptoms. The evaluation is needed to track his/her progress in response to intensive ABA therapy services, determine his/her eligibility for continued ABA services through Michigan Autism Services, and direct treatment planning. [Describe ABA treatment services; briefly discuss other current services and interventions, as well as any recent updates for the child]

Results of cognitive testing indicated [describe updated cognitive and adaptive behavior skills assessment]

[Describe updated observational assessment, report from caregivers, and other available information regarding child's current ASD symptoms and progress in treatment]

[Summarize ASD diagnosis, including whether continued ABA is recommended]  
[Describe comorbid diagnoses and other treatment considerations]



[Summarize child strengths]

Diagnostic Summary:

DSM-5 Diagnosis:	DSM-5 Code	ICD-10 Code
Autism Spectrum Disorder, Mild Severity	299.00	F84.0
Language Disorder, Mixed Expressive and Receptive	315.0	F80.9

The following additional recommendations are provided given XX's current presenting concerns. XX's treatment team may be helpful in continuing to facilitate implementation of these recommendations.

[describe relevant recs for child's current needs: Clinical/Medical, Educational, Other recs for the family]

Results and recommendations were discussed with XX's mother in a brief feedback session on X date/immediately following the evaluation. Any questions regarding this consultation should be directed to the undersigned.

[Your signature and supervisor signature if needed]

\*\*\*\*\*Appendix: Test Scores Tables\*\*\*\*\*

# Michigan Autism Spectrum Disorder (ASD)

## ***Resources for Providers***

### ***Post Identification Guide for Providers: Education & Treatment Referral for Young Children with ASD***



#### **Overview**

Finding out a child has ASD can be a difficult experience for families. Your support is crucial, and effective communication to families can answer many potential questions and help them identify clear next steps. You can help by:

- Ensuring that comorbid conditions are identified and addressed.
- Emphasizing family participation in treatment and support from the beginning.
- Explaining that treatment will help their child reach his or her full potential. Avoid making negative long-term predictions or stating that treatment will ‘fix’ the child.
- Helping families focus on accepting and enjoying their child, while pursuing interventions and services that work for the family as a whole.
- Working together with parents and caregivers to set goals for growth through family assistance and professional interventions.

#### **Evidence Based Interventions**

It is important for families to seek and find the best resources that will result in positive outcomes since there is an overwhelming amount of treatment information. It is important that families are guided to evidence based care for ASD and that professionals have the ability to assist in this process.

Evidence based practices for young children with ASD according to the [National Professional Development Center](#) (NPDC) of ASD:

- Applied Behavioral Analysis (ABA) / Behavioral Interventions
- Naturalistic Interventions
- Communication/Language Interventions
- Peer-Mediated Intervention and Social Skills Training
- Antecedent-Based Intervention (Prevention and Environmental Modifications)
- Parent-Implemented Intervention & Training (e.g. [Project Impact](#))

# Michigan Autism Spectrum Disorder (ASD)

## *Resources for Providers*

Many resources and services are available to families. However knowing where to find the information and services can be overwhelming. It is imperative that families are guided to evidence-based information and care as soon as possible in order to have the most positive opportunities and outcome.

### Important Referral Information for Providers to Share with Families:

#### School Services

- [Early On](#)® (birth through age 3): Early On website or call 1-800-EARLY ON
- [Build Up Michigan](#) (ages 3 through 5): Link to Build up Michigan or call your [Child Find Coordinator](#) or call the Michigan Special Education Information Line at 1-888-320-8384
- [Local school district for early childhood services](#) (age 3 and up): call the local school district's special education office and/or the school's principal

**Behaviorally-Based Interventions:** Be specific about the child's needs and your recommendations such as intensive Applied Behavior Analysis (ABA) or focal behavioral intervention. Note: Home and clinic services are available through Medicaid, some private insurance, and private pay.

#### Support Services

- [Autism Alliance of Michigan](#) (AAOM) Navigator Program: [navigator@aaomi.org](mailto:navigator@aaomi.org) / 877-463-AAOM
- Parent mentoring and learning for school services, [Michigan Alliance for Families](#) (MAF) website for local contacts or call 800-552-4821
- Parent advocacy and legal assistance for disability services, [Michigan Protection & Advocacy Services](#) (MPAS) at 800-288-5923 or [Arc Michigan](#) at call 800-292-7851
- Local parent support group referral
- Michigan Autism Council: [After a Diagnosis Information Guide](#)
- [Autism Speaks Toolkits](#)

#### Medical & Allied Health Care

- Continue with general pediatrician monitoring and request parental consent to send the evaluation report to the child's pediatrician for coordinated care
- Address any focal medical issues (e.g., sleeping, feeding)
- Neurology & Psychiatric referral if needed
- Ancillary health supports as needed per evaluation data, including speech therapy, occupational therapy, and physical therapy. Note: These services often require preauthorization and families may need a prescription from the pediatrician to access care
- Counseling, including individual, parent, or family therapy

**Resource for Evaluators:** Autism Speaks - [The Clinician's Guide to Providing Effective Feedback to Families Affected by Autism](#)



# Michigan Autism Spectrum Disorder (ASD)

## ***Resources for Providers***

**Use this template to provide specific local resources:**

<b>Local School Services</b>
Intermediate School District:
District Special Education Services:
<i>Early On</i> ®:
Other:
<b>Local Behaviorally-Based Service Providers</b>
Private Insurance(s):
Prepaid Inpatient Health Plan(s) / Medicaid:
Medicaid Health Plan(s):
<b>Local Support Services</b>
Parent Group(s):
Advocacy:
Play groups:
Other:
<b>Local Medical &amp; Allied Health Care</b>
Neurology:
Psychiatric:
Primary Care/Pediatrician(s):
Specialist(s):
Ancillary Health Supports:
<b>Local Other</b> ( <i>Local Resources, etc.</i> )

# Michigan Autism Spectrum Disorder (ASD)

---

## ***Resources for Providers***



# Michigan Autism Spectrum Disorder (ASD)

## ***Resources for Parents***

### **My child has been diagnosed with Autism Spectrum Disorder. What is my next step?**

Try not to feel overwhelmed, but find good information and take it step by step. This quick guide will get you started and link you to useful resources. Also remember to take care of yourself during the process. Having a child with ASD can affect everyone in the family.



### **Get early intervention services as soon as possible.**

#### **Is your child covered by private insurance?**

Contact your insurance company to find out if Applied Behavior Analysis (ABA), speech therapy, psychological, or other services are available for children with ASD (See the [Guide for Insurance Representative Communications](#) for questions to ask.)

#### **Is your child covered by Medicaid Insurance?**

Contact your local Community Mental Health to access Applied Behavior Analysis, speech therapy, psychological, or other services.

Ask anyone who is working with your child how you can teach and support your child at home. Use goals and strategies taught at school and in therapy during your daily routines.

Connect with your [local autism support group](#). Also be sure to take care of yourself and your family. This might include seeking parent training or sibling support groups.

#### **To determine eligibility for free educational and family services contact:**

- [Early On](#)® Michigan (birth - age 3) Link to the Early On website or call 1-800-Early On
- [Build Up Michigan](#) (ages 3 through 5) Link to the Build Up Michigan website or call your [Child Find Coordinator](#) or the Michigan Special Education Information Line at 1-888-320-8384
- Your local school district (ages 3 and up) at [find your school district](#) or call your local school district administration office.

# Michigan Autism Spectrum Disorder (ASD)

## *Resources for Parents*

Educate yourself through trainings, conferences, websites, and books. It is important that you find information that has good supporting evidence such as these websites:

- Autism Spectrum Disorders – [Centers for Disease Control \(CDC\)](#)
- Evidence-Based Practices – [National Professional Development Center on ASD \(NPDC\)](#) and [Association for Science in Autism Treatment \(ASAT\)](#)
- Special Education Resources for Families – [Michigan Alliance for Families \(MAF\)](#)

Be a member of your child's school team and health care team. Advocate for your child by setting goals and developing plans for now and in the future. Working together is very important. You are the center of your child's team!

Talk to your immediate family, extended family, and friends about what your child needs and how they can help. A good book to share with others is [10 Things Every Child with Autism Wishes You Knew](#) by Ellen Notbohm.

Develop a safety plan, especially if your child has a tendency to wander. Find information at [Autism Safety Project Resources](#).

If you need additional guidance, find help from the Autism Alliance of Michigan at [MiNavigator Program](#) or 1-877-463-AAOM.

One suggested resource for families of newly identified children is the [First 100 Day Kit](#) by Autism Speak





## Standard Template for WSA Form for Autism Services, Comprehensive Diagnostic Evaluation & Re-Evaluation Form

Referral Date: \_\_\_\_\_ Evaluation Date: \_\_\_\_\_ PIHP: \_\_\_\_\_

Consumer Name: \_\_\_\_\_ Age: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Provider/Agency: \_\_\_\_\_

Evaluator Name/Credentials: \_\_\_\_\_

Tools Administered: ☐ Clinical Interview ☐ ASD Interview/ADI-R ☐ ADOS-2  
☐ Cognitive/Develop. ☐ Adaptive Behavior ☐ DD-CGAS  
☐ Other: \_\_\_\_\_

ADOS-2 Module Administered: ☐ Todd A ☐ Todd B ☐ Mod 1A ☐ Mod 1B ☐ Mod 2A ☐ Mod 2B ☐ Mod 3 ☐ Mod 4

ADOS-2 Overall Total Score: \_\_\_\_\_ \*Mod. 4 Only: Comm: \_\_\_\_\_ Social Int: \_\_\_\_\_ Comm.+ Soc.Int: \_\_\_\_\_

ADOS-2 Classification: Autism ☐ Autism Spectrum ☐ Non-Spectrum ☐ ADOS-2 could not be scored ☐ Specify why \_\_\_\_\_

DD-CGAS Total Score: \_\_\_\_\_

Clinical Diagnosis: ☐ Autism Spectrum Disorder ☐ Other(s) Specify: \_\_\_\_\_

Medical Necessity Criteria:

- A.** Currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, Lack of:

	Social-emotional reciprocity, <i>ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.</i>
	Nonverbal communicative behaviors used for social interaction, <i>ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.</i>
	Developing, maintaining, and understanding relationships, <i>ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.</i>

- B.** Currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by the following:

	Stereotyped or repetitive motor movements, use of objects, or speech ( <i>e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases</i> ).
	Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior ( <i>e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day</i> ).
	Highly restricted, fixated interests that are abnormal in intensity or focus ( <i>e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest</i> ).
	Hyper- or hypo activity to sensory input or unusual interests in sensory aspects of the environment ( <i>e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement</i> ).

Medical necessity and recommendation for Behavioral Health Treatment/ABA was made by a physician, licensed psychologist or other licensed qualified practitioner (QLP) in the State of Michigan:

☐ Yes

☐ No

Feedback Session Completed with Family: ☐ Yes ☐ No Date of

Feedback: \_\_\_\_\_



Was IPOS Case Holder Provider Present:

☐ Yes (If yes, ☐ Face-to-face ☐ Teleconference)

☐ No

Case Action Requested:

☐ Not Qualified

☐ Declined Benefit

☐ Enrollment into ASD BHT Services

*Notes: (Indicate any comments about the evaluation process, explanation of medical necessity determination, or comments about family's interest in BHT/ABA services; any notes about cancellations, reschedules, no call/no shows, etc. with dates & reasons for delay in service )*



## Glossary of Terms and Acronyms

Acronym	Term	Definition
AAP	American Academy of Pediatrics	An association comprised of pediatricians across the U.S. involved in different activities to optimize all aspects of health, including physical, mental, and social, for all children under the age of 18.
ABA	Applied Behavior Analysis	A process of systematically applying a variety of evidence-based practices to improve socially significant behavior (e.g. those important for successful functioning in a variety of environments). ABA is founded in the scientific principles of behavior and learning and includes, but is not limited to, functional communication training, discrete trial training, reinforcement, prompting, incidental teaching, schedules, naturalistic teaching, shaping, and pivotal response training.
ABI	Applied Behavioral Intervention	Per the Michigan 1915(i) State Plan Amendment, a less intensive and focal model of ABA where treatment is provided an average of 5 to 15 hours per week.
ABLLS-R	Assessment of Basic Language and Learning Skills Revised	An assessment tool and treatment guide used for the evaluation and instruction of language and critical learner skills for children with autism or other developmental disabilities.
ADI-R	Autism Diagnostic Interview - Revised	A structured interview tool that may be used to diagnose Autism Spectrum Disorder (ASD), plan treatment, and distinguish autism from other developmental disorders.
ADOS-2	Autism Diagnostic Observation Schedule	An instrument that may be used in the diagnostic and assessment process for Autism Spectrum Disorder (ASD).
AFLS	Assessment of Functional Living Skills	An assessment tool and treatment guide used for the evaluation and instruction of essential life skills so that individuals with Autism Spectrum Disorder (ASD) or developmental delays may live independently.
ASD	Autism Spectrum Disorder	A developmental disability affecting social skills, communication, and behavior. Abilities in these areas range depending on the individual.
	Asperger's Syndrome	An Autism Spectrum Disorder (ASD) regarded as the "high functioning" end of the spectrum. Individuals typically have difficulty with social interactions, exhibit a restricted range of interests and/or repetitive behaviors, and show delayed motor development. However, individuals with Asperger's do not have significant delays or difficulties in language or cognitive development.
	Autistic Disorder	An Autism Spectrum Disorder (ASD) characterized by severe deficits in social skills, communication, and adaptive behavior.



## Glossary of Terms and Acronyms

BACB	Behavior Analyst Certification Board	A national nonprofit corporation established to coordinate BCBA-D, BCBA, BCaBA, and RBT credentials.
BCaBA	Board Certified Assistant Behavior Analyst	A bachelor level certification for a person who may provide behavioral assessment, behavioral intervention, and behavioral observation and direction under the supervision of a BCBA-D or BCBA.
BCBA-D	Board Certified Behavior Analyst-Doctoral	A doctoral level certification for a person who may provide behavioral assessment, behavioral intervention, and behavioral observation and direction.
BCBA	Board Certified Behavior Analyst	A master's level certification for a person who may provide behavioral assessment, behavioral intervention, and behavioral observation and direction.
BHT	Behavioral Health Treatment	The “umbrella” of behavioral interventions, including Applied Behavior Analysis (ABA), which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized substantial scientific and clinical evidence.
BPOC	Behavior Plan of Care	A behavior plan that defines how behavior goals in the child's IPOS will be attained.
BT	Behavior Technician	The individual responsible for the direct implantation of the BHT/ABA services under the supervision of a BCBA-D, BCBA, or BCaBA. A BT is not credentialed by the BACB.
BTPRC	Behavior Treatment Plan Review Committee	The BTPRC reviews and approves or disapproves treatment plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit aggressive, self-injurious, or other challenging behaviors.
CBI	Comprehensive Behavioral Intervention	An intensive BHT service level where services are provided an average of 16 to 25 hours per week.
CMHSP	Community Mental Health Services Program	A government contracted entity that manages mental health services for people enrolled in Medicaid.
CMS	Centers for Medicare & Medicaid Services	An agency within the Department of Health and Human Services who provide funds and guidelines to public insurances.
CPT	Current Procedural Terminology	A coding system used to report medical procedures and services in both private and public insurance programs.
DD	Developmental Disability/Disorder	A group of disabilities characterized by deficits in motor skills, learning, language, and behavior. These conditions arise during a child's development and impact their everyday functioning.
DD-CGAS	Developmental Disability Children's Global Assessment Scale	An evaluation tool used to determine the level of functioning of a child with a developmental disability

## Glossary of Terms and Acronyms

		compared to neurotypical peers of the same chronological age.
DSM-4	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition	The fourth edition of the standard classification of mental disorders containing a listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. healthcare system.
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition	The fifth edition of the standard classification of mental disorders containing a listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. healthcare system.
EIBI	Early Intensive Behavioral Intervention	Per the Michigan 1915(i) State Plan Amendment, an intensive model of ABA where treatment is provided an average of 10 to 20 hours per week.
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment Benefit	A benefit that provides comprehensive and preventive health care services for children under the age of 21 who also are enrolled in Medicaid.
FBA	Functional Behavior Assessment	An assessment used to identify the function of certain behaviors of an individual with a developmental disability.
FBI	Focused Behavioral Intervention	A BHT service level where services are provided an average of 5 to 15 hours per week.
HCPCS	Healthcare Common Procedure Coding System	A coding system used in the billing process to CMS.
IDD	Intellectual Developmental Disability/Disorder	A developmental disability specifically characterized by deficits in intellectual functioning and adaptive behavior.
IEP	Individualized Education Program	A plan developed by a team, for eligible students with disabilities under state and federal special education law, that describes the offer of free appropriate public education in the least restrictive environment, including special education, and/or related services and/or supplementary aids and services.
IFSP	Individualized Family Service Plan	A plan for infants and toddlers (birth-3) that includes early intervention services. The IFSP may also include special education if the child qualifies for special education.
IPOS	Individual Plan of Service	Developed through the Person-Centered Planning (PCP) process, the IPOS includes information about the individual, goals and outcomes, and the services needed to achieve those goals and outcomes.
LP	Licensed Psychologist	A doctoral certification for a person who may provide behavioral assessment, behavioral intervention, and behavioral observation and direction.
LLP	Limited Licensed Psychologist	A master's level certification for a person who may provide behavioral assessment, behavioral intervention, and

## Glossary of Terms and Acronyms

		behavioral observation and direction under the supervision of a BCBA.
M-CHAT	Modified Checklist for Autism in Toddlers	A screening tool used to help identify Autism Spectrum Disorder (ASD) in children ages 16 months to 30 months.
MSA	Medical Services Administration	The office within the Michigan Department of Health and Human Services that has primary oversight of Michigan's Medicaid program, which includes administration of Medicaid programs.
MDHHS	Michigan Department of Health and Human Services	The department responsible for health policy and management of the state's health, mental health, and substance use care system.
PDD-NOS	Pervasive Developmental Disorder, Not Otherwise Specified	An Autism Spectrum Disorder (ASD) defined as having some but not all characteristics of ASD, such as social, communication, and/or behavior deficits. Occasionally, the individual will exhibit significant characteristics in one area but will show mild or no characteristics in another area.
PIHP	Prepaid Inpatient Health Plan	The entity responsible for managing behavioral health services for individuals enrolled in Medicaid.
RBT	Registered Behavior Technician	The individual responsible for the direct implantation of the BHT/ABA services under the supervision of a BCBA-D, BCBA, or BCaBA. A RBT is credentialed by the BACB.
SCQ	Social Communication Questionnaire	A screening tool used to help identify Autism Spectrum Disorder (ASD) in children ages 4-6.
WSA	Web Support Application	The management tool used for enrollment and monitoring of various programs, including the Habilitation Supports Waiver, Waiver for Children with Serious Emotional Disturbance, Children's Waiver Program, and Autism Program.
VB-MAPP	Verbal Behavior Milestones Assessment and Placement Program	An assessment tool and treatment guide used for the evaluation and instruction of language skills for children with Autism Spectrum Disorder (ASD) or other individuals who demonstrate language delays.



